NEVADA PUBLIC EMPLOYEES' BENEFITS PROGRAM

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Quality.
Affordability.

CONSUMER DRIVEN HEALTH PLAN MASTER PLAN DOCUMENT

PLAN YEAR 2024

(EFFECTIVE JULY 1, 2023 – JUNE 30, 2024)

Public Employees' Benefits Program
901 S. Stewart Street, Suite 1001
Carson City, Nevada 89701

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Amendment Log

Any amendments, changes or updates to this document will be listed here. The amendment log will include what sections are amended and where the changes can be found.

Welcome PEBP Participant

Welcome to the State of Nevada Public Employees' Benefits Program (PEBP). PEBP offers medical, vision, dental, and life insurance, in addition to flexible spending accounts, and other voluntary benefits for eligible state and local government employees, retirees, and their eligible dependents.

As a PEBP participant, you may access whichever benefit plan offered in your geographical area that best meets your needs, subject to specific eligibility and plan requirements. These plans include the Consumer Driven Health Plan (CDHP) with a Health Savings Account (HSA) or a Health Reimbursement Arrangement (HRA), Exclusive Provider Organization Plan, Low Deductible PPO Plan, and the Health Plan of Nevada HMO Plan. You are also encouraged to research plan provider access and quality of care in your service area.

All PEBP participants choosing the Consumer Driven Health Plan should examine this document, the PEBP Self-Funded PPO Dental Plan Master Plan Document (MPD), the Active Employee Health and Welfare Wrap Plan, Retiree Health and Welfare Wrap Plan, Section 125 Document, and the PEBP Enrollment and Eligibility Master Plan Document. These documents are available at www.pebp.state.nv.us or by calling 775-684-7000, (702) 486-3100, or 1-800-326-5496.

Master Plan Documents are a comprehensive description of the benefits available to you. Relevant statutes and regulations are noted in the Active Employee Health and Welfare Plan Document and Retiree Health and Welfare Wrap Plan Document for reference. In addition, helpful material is available from PEBP or any PEBP vendor listed in the Participant Contact Guide.

PEBP encourages you to stay informed of the most up to date information regarding your health care benefits. It is your responsibility to know and follow the requirements as described in PEBP's Master Plan Documents.

Sincerely,

Public Employees' Benefits Program

Introduction

This Master Plan Document describes the Consumer Driven Health Plan (herein after referred to the "Plan" or "CDHP") benefits. This Plan offers In-Network and Out-of-Network benefits and is a self-funded plan administered by PEBP and governed by the State of Nevada. The Plan is available to eligible employees, retirees, and their eligible dependents participating in the Public Employees' Benefits Program (PEBP).

The benefits offered with the CDHP include medically necessary medical, behavioral health, prescription drug, vision, and dental coverage. Additional benefits include basic life insurance for active employees and eligible retirees. The medical, behavioral health, prescription drug, and vision benefits are described in this document. For information regarding the dental and life insurance benefits, refer to the PEBP PPO Dental Plan and Summary of Benefits for Life Insurance Master Plan Document. The CDHP provides a Health Savings Account (HSA) for eligible employees and a Health Reimbursement Arrangement (HRA) for eligible retirees and active employees who are ineligible for the HSA.

An independent third-party Claims Administrator pays the claims for the medical, dental and vision benefits. An independent pharmacy benefit manager pays the claims for prescription drug benefits.

This document is intended to comply with the Nevada Revised Statutes (NRS) Chapter 287, and the Nevada Administrative Code (NAC) 287 as amended and certain provisions of NRS 695G and NRS 689B. The Plan Sponsor certifies that this Article incorporates the provisions set forth in 45 CFR Section 164.504(f)(2)(ii) and the Plan Sponsor agrees to such provisions in accordance with 45 CFR Section 164.504(f)(2)(ii).

The Plan described in this document is effective **July 1, 2023**, and unless stated differently, replaces all other CDHP medical and prescription drug benefit plan documents/summary plan descriptions previously provided to you.

All provisions of this document contain important information. It will help you understand and use the benefits provided by this Plan. You should review it and show it to members of your family who are or will be covered by the Plan. It will give you an understanding of the coverage provided, the procedures to follow in submitting claims, and your responsibilities to provide necessary information to the Plan. Be sure to read the *Benefit Limitations and Explanations*, and *Exclusions* and *Key Terms and Definitions* sections. Remember, not every expense you incur for health care is covered by this Plan.

PEBP intends to maintain this Plan indefinitely, but reserves the right to terminate, suspend, discontinue, or amend the Plan at any time and for any reason. Members should keep informed of this document as the Plan is amended periodically. If those later notices describe a benefit or procedure that is different from what is described here, you should rely on the later information. Be sure to keep this document, along with notices of any Plan changes, in a safe and convenient place where you and your family can find and refer to them.

Per NRS 287.0485 no officer, employee, or retiree of the State has any inherent right to benefits provided under the PEBP.

Suggestions for Using this Document

This document provides important information about your benefits. We encourage you to pay attention to the following:

- The *Table of Contents* provides you with an outline of the sections.
- The *Participant Contact Guide* helps you become familiar with PEBP vendors and the services they provide.
- The *Participant Rights* section describes your rights and responsibilities as a participant of this Plan.
- The *Key Terms and Definitions* section explains many technical, medical, and legal terms that appear in the text.
- The *Eligible Medical Expenses* and *Non-Eligible Medical Expenses*, *Summary of the CDHP Components, Schedule of Medical Benefits, Schedule of Prescription Drug Benefits, Key Terms and Definitions*, and *Exclusions* sections describe your benefits in more detail.
- The *Preventive Care/Wellness Services* section provides wellness information that can help you proactively manage your health.
- The *Utilization Management* section provides information on what health care services that require prior authorization and the process to request prior authorization.
- The *Claims Administration* section describes how benefits are paid and how to file a claim.
- The *Appeals Procedure* section describes how to request a review (appeal) if you are dissatisfied with a claim decision.
- The *Coordination of Benefits* section describes situations where you have coverage under more than one health care plan, including Medicare.

Accessing Other Benefit Information:

You will also want to access the following documents for information related to dental, life, flexible spending accounts, enrollment and eligibility, Consolidated Omnibus Budget Reconciliation Act (COBRA), third-party liability and subrogation, Health Insurance Portability and Accountability Act (HIPAA) and Privacy and Security and mandatory notices. These documents are available at www.pebp.state.nv.us.

- State of Nevada PEBP Active Employee Health and Welfare Wrap Plan Document
- State of Nevada PEBP Retiree Health and Welfare Wrap Plan Document
- Consumer Driven Health Plan (CDHP) Master Plan Document
- CDHP Summary of Benefits and Coverage for Individual and Family
- Low Deductible PPO Plan Master Plan Document

- Low Deductible PPO Plan Summary of Benefits and Coverage for Individual and Family
- PEBP PPO Dental Plan and Summary of Benefits for Life Insurance Master Plan Document
- Exclusive Provider Organization Plan Master Plan Document
- Exclusive Provider Organization Plan Summary of Benefits and Coverage for Individual and Family
- Health Plan of Nevada Evidence of Coverage (EOC) and Summary of Benefits and Coverage
- PEBP Enrollment and Eligibility Master Plan Document
- Flexible Spending Accounts (FSA) Summary Plan Description
- Section 125 Health and Welfare Benefits Plan Document
- Medicare Retiree Health Reimbursement Arrangement Summary Plan Description

Participant Rights

You have the right to:

- Participate with your health care professionals in your health care decisions and have your health care professionals give you information about your condition and your treatment options.
- Receive the benefits for which you have coverage.
- Be treated with respect and dignity.
- Privacy of your personal health information, consistent with State and Federal laws, and the Plan's policies.
- Receive information about the Plan's organization and services, the Plan's network of health care professionals and providers and your rights.
- Candidly discuss with your physicians and providers appropriate or medically necessary care for your condition, regardless of cost or benefit coverage.
- Make recommendations regarding the organization's participants' rights and responsibilities policies.
- Express respectfully and professionally, any concerns you may have about PEBP or any benefit or coverage decisions the Plan, or the Plan's designated administrator, makes.
- Refuse treatment for any conditions, illness, or disease without jeopardizing future treatment and be informed by your physician(s) of the medical consequences.

Summary of the CDHP Components

Highlights of the Plan

The CDHP is a PEBP administered Preferred Provider Organization (PPO) High Deductible Health Plan which provides In-Network and Out-of-Network benefits. As a member, you receive coverage for many medically necessary services and supplies, subject to any Benefit Limitations and Explanations and *Exclusions*. This is an open access PPO Plan and does not require a referral to see a specialist.

The Plan includes:

- Coverage for participants residing nationwide (in- and outside of Nevada).
- In-and Out-of-Network benefits.
- Reimbursement for *Eligible Medical Expenses* described in this document (and as determined by the Plan Administrator) for participants residing permanently, part time, or while traveling outside of the United States. Refer to the *Out-of-Country Medical and Vision Purchases* section.
- Coverage for eligible preventive care services at 100% when using In-Network providers. Refer to the *Preventive Care/Wellness Services* section for more information.
- Health care resources and tools to assist you in making informed decisions about your and your family's health care services. For more information log in to your E-PEBP member portal account at www.pebp.state.nv.us.

The CDHP is coupled with either a Health Savings Account (HSA) or a Health Reimbursement Arrangement (HRA).

Plan Year Deductibles and Out-of-Pocket Maximums				
	In-Network Deductible	**In-Network Out-of-Pocket Maximum**	**Out-of-Network Deductible**	**Out-of-Network Out-of-Pocket Maximum**
Individual (self-only coverage)	$1,500	$4,000	$1,500	$10,600
Family	Family: $3,000 Individual family member: $2,800	Family: $8,000 Individual family Member: $6,850	Family: $3,000 Individual family member: $2,800	$21,200
In-Network and Out-of-Network Deductibles and Out-of-Pocket Maximums are not interchangeable. The Deductibles and Out-of-Pocket Maximums accumulate separately for In-Network and Out-of-Network provider expenses. See Family Deductible explanation below.				

Deductibles

The Plan Year Deductibles (combined medical and prescription drug) includes two tiers:

- **Individual Deductible**: Applies when only one person is covered on the Plan (self-only coverage).
- **Family Deductible**: Applies when two or more individuals are covered on the same Plan (e.g., Employee plus Spouse, Employee plus Spouse and Child, etc.). The Family Deductible may be met through a combination of *Eligible Medical Expenses* from all covered family members. The In-Network Family Deductible includes a "Individual Family Member" embedded Deductible. This means one single member of the family is only required to meet the Individual Family Member Deductible before the Plan starts to pay Coinsurance for that member.

The Individual and Family Deductibles start July 1st (the first day of the Plan Year) and reset the following Plan Year on July 1st. This Plan does not include a Deductible carryover or rollover provision.

During the Plan Year, you are responsible for paying for your eligible medical and prescription drug expenses (except eligible Preventive Services provided In-Network) , including amounts exceeding the Plan's reference-based pricing for hip and knee replacement, preauthorization penalties, out of pocket.

In-Network Individual Deductible

The In-Network Individual Deductible applies when only one person is covered on the Plan. For this Plan Year, the Deductible is **$1,500**. Participants are responsible for paying Out-of-Pocket for eligible medical and prescription drug expenses that are subject to the Deductible. Once the Individual Deductible is met, the Plan will pay its cost-share of eligible benefits. (In-Network and Out-of-Network Deductibles are not interchangeable, meaning the Deductibles accumulate separately for In-Network provider expenses and Out-of-Network provider expenses.) Deductible credit is based on the date the medical or prescription drug expense is received by the Plan and not on the date of service.

Out-of-Network Individual Deductible

The Out-of-Network Individual Deductible applies when only one person is covered on the Plan. For this Plan Year, the Deductible for Eligible Medical Expenses received Out-of-Network is **$1,500**. Participants are responsible for paying Out-of-Pocket for eligible medical (prescription drugs are not covered Out-of-Network) expenses up to the Plan Year Deductible. Once the Individual Deductible is met, the Plan will pay its cost-share of eligible benefits. (In-Network and Out-of-Network Deductibles are not interchangeable, meaning the Deductibles accumulate separately for In-Network provider expenses and Out-of-Network provider expenses.) Deductible credit is based on the date the medical or prescription drug expense is received by the Plan and not on the date of service.

In-Network Family Deductible

The In-Network Family Deductible applies when two or more individuals are covered on the same Plan. For this Plan Year, the Family Deductible is **$3,000** and includes a **$2,800** embedded "Individual Family Member" Deductible. For a participant covered with one or more dependents, this Plan will pay benefits for eligible In-Network medical and prescription drug expenses for the entire family after the **$3,000** Family Deductible is met; or the Plan will pay benefits for one single family member who has met the **$2,800** "Individual Family Member" Deductible (under no circumstances will one single family member be required to pay more than **$2,800** toward the **$3,000** Family Deductible). The **$3,000** In-Network Family Deductible may be met by any combination of Eligible Medical Expenses from *two or more* covered individuals in the family. The Family Deductible (including "Individual Family Member" Deductible) accumulates separately for In-Network provider and Out-of-Network provider expenses. Deductible credit is based on the date the medical or prescription drug expense is received by the Plan and not on the date of service.

Out-of-Network Family Deductible

The Out-of-Network Family Deductible applies when two or more individuals are covered on the same Plan. For this Plan Year, the Family Deductible is **$3,000** and includes a **$2,800** "Individual Family Member" Deductible. For a participant covered with one or more dependents, this Plan will pay benefits for eligible Out-of-Network medical and vision (prescription drugs are not covered Out-of-Network) expenses for the entire family after the **$3,000** Family Deductible is met; or the Plan will pay benefits for one single family member who has met the **$2,800** "Individual Family Member" Deductible (under no circumstances will one single family member be required to pay more than **$2,800** toward the **$3,000** Out-of-Network Family Deductible). The **$3,000** Family Deductible may be met by any combination of Eligible Medical Expenses from *two or more* covered individuals in the family. The Family Deductible (including "Individual Family Member" Deductible) accumulates separately for In-Network provider and Out-of-Network provider expenses. Deductible credit is based on the date the medical or prescription drug expense is received by the Plan and not on the date of service.

Coinsurance

Coinsurance is the percentage of costs that generally you and the Plan pay for Eligible Medical Expenses after your Deductible is met. If you receive covered health care services using a health care provider who is a participating provider of this Plan's PPO network, you will be paying less money out of your pocket. This Plan generally pays **80%** of the In-Network provider's contract rate and you are responsible for paying the remaining **20%**. If you use an Out-of-Network provider (a non-participating provider, meaning the provider is not contracted with the PPO network), the Plan benefit may be reduced to **50%** of the Maximum Allowable Charge, and you are responsible for paying the remaining **50%**. Out-of-Network providers can also bill you directly for any difference between their billed charges and the Maximum Allowable Charge allowed by this Plan, except when prohibited by law.

Out-of-Pocket Maximums

In-Network Out-of-Pocket Maximums

The In-Network Out-of-Pocket Maximum (OOP Maximum) is the maximum amount you will pay for In-Network eligible medical and prescription drug expenses during the Plan Year. The Out-of-Pocket costs you pay toward your Deductible and Coinsurance for Eligible Medical Expenses accumulate toward your OOP Maximum. The OOP Maximum for:

- An Individual (covered as self-only) is **$4,000**
- Family coverage (participant plus one or more covered dependents) is **$8,000**
  - The Family OOP Maximum includes a **$6,850** embedded "Individual Family Member" OOP Maximum. An Individual Family Member OOP Maximum means one single family member will not pay more than **$6,850** in the Plan Year for Eligible Medical Expenses.

Once an Individual or Family satisfies the OOP Maximum, the Plan will pay 100% of all eligible medical and prescription drug expenses for the remainder of the Plan Year. The OOP Maximum accumulates on a Plan Year basis and resets to zero at the start of a new Plan Year. The accumulation of Eligible Medical Expenses toward the OOP Maximum is based on the date the medical or prescription drug expense is received by the Plan and not on the date of services.

Only Eligible Medical Expenses that apply to the Deductible and Coinsurance will apply to the OOP Maximum. The OOP Maximum does not include premiums, cost-sharing for non-covered supplies and services, penalties for failure to get preauthorization, amounts exceeding the Plan's allowable charge for hip and knee replacement, expenses associated with denied claims, ancillary charges and amounts that Out-of-Network providers bill and are payable that are greater than this Plan's Maximum Allowable Charge. This list is not all inclusive and may not include certain services and supplies that are not listed here.

For this section only, all references to the OOP Maximum, Eligible Medical Expenses, Deductible and Coinsurance are specific to In-Network benefits.

Out-of-Network Out-of-Pocket Maximum

The Out-of-Network Out-of-Pocket Maximum (OOP Maximum) is the maximum amount you will pay for Eligible Medical Expenses (excluding prescription drugs) during the Plan Year. The Out-of-Pocket costs you pay toward your Deductible and Coinsurance for Eligible Medical Expenses accumulate toward your OOP Maximum. The OOP Maximum for:

- Individual (covered as self-only) is **$10,600**.
- Family coverage (participant plus one or more covered dependents) is **$21,200**. (The Family coverage tier does <u>not</u> include an embedded Individual Family Member OOP Maximum.)

Once the OOP Maximum is met, the Plan will pay 100% of all Eligible Medical Expenses (excluding Out-of-Network prescription drug expenses) for the remainder of the Plan Year. The OOP Maximum accumulates on a Plan Year basis and resets to zero at the start of a new Plan Year.

The accumulation of Eligible Medical Expenses toward the OOP Maximum is based on the date the medical expense is received by the plan and not on the date of services.

The Family OOP Maximum (for Out-of-Network services only) can be met by one person or by a combination of Out-of-Pocket Eligible Medical Expenses from all covered family members.

Only Eligible Medical Expenses that apply to the Deductible and Coinsurance will apply to the OOP Maximum. The OOP Maximum does not include premiums, cost-sharing for non-covered supplies and services, penalties for failure to obtain preauthorization, amounts exceeding the Plan's allowable charge for hip and knee replacement, expenses associated with denied claims, ancillary charges, and any amount that Out-of-Network providers bill and are payable that are greater than this Plan's Maximum Allowable Charge. This list is not all inclusive and may not include certain services and supplies that are not listed here.

All references to the Out-of-Network, OOP Maximum, Eligible Medical Expenses, Deductible and Coinsurance in this section are specific to Out-of-Network benefits.

In- and Out-of-Network Maximums are not interchangeable and cannot be combined to reach your Plan Year OOP Maximum.

Description of In-Network and Out-of-Network

Provider Network

The Plan or its designee arranges for providers to participate in a PPO network. For more information, see the Participant Contact Guide section of this document. In-Network providers are hospitals, physicians, medical laboratories, and other health care providers located within a service area who have agreed to provide health care services and supplies at negotiated discount fees. Network providers are not the Plan's employees or employees of any Plan designee.

The contracted PPO Network is responsible for credentialing providers by confirming public information about the providers' licenses and other credentials but does not assure the quality of the services provided.

Before obtaining services, you should always verify the network status of a provider. A provider's status may change. You are responsible for verifying a provider's network status prior to receiving services, even when you are referred by another In-Network provider. You can verify the provider's status by calling the third-party administrator or on the PEBP website in the Find a Provider section. The provider listing is maintained and updated by the contracted network.

It is possible that you might not be able to obtain specific services from an In-Network provider. The provider network is subject to change. Or you might find that an In-Network provider may not be accepting new patients. If a provider leaves the network or is otherwise not available, you must choose another In-Network provider to get In-Network benefits.

Do not assume that an In-Network provider's agreement includes all Eligible Medical Expenses. Some In-Network providers agree to provide only certain covered expenses, but not all covered expenses. Some In-Network providers choose to be an In-Network provider for only some products and services. You may contact the third-party administrator for assistance in choosing a provider or with questions about a provider's network participation.

This plan also adheres to NRS 695G.164 for required provision in certain plans concerning coverage for continued medical treatment

In-Network Provider Benefits

The Plan provides In-Network benefits when the services are provided by an In-Network provider and generally pays at a higher amount than Out-of-Network benefits. In-Network benefits are payable for covered Eligible Medical Expenses.

When a participant uses the services of a PPO network (In-Network) health care provider, the participant is responsible for paying the applicable Deductible and Coinsurance on the discounted fees for medically necessary services or supplies, subject to the Plan's coverage, limitations, and exclusions.

If you receive medically necessary services or supplies from an In-Network provider, you will pay a lower Coinsurance than if you received those services or supplies from a health care provider who is not in the PPO network (Out-of-Network). In-Network providers have agreed to accept the Plan's payment (plus any applicable Coinsurance you are responsible for paying) as payment in full. The In-Network health care provider generally deals with the Plan directly for any additional amount due.

Out-of-Network Provider Benefits

Out-of-Network, Eligible Medical Expenses are subject to applicable Deductibles and a Coinsurance rate of 50% of eligible billed charges and subject to the Plan's Maximum Allowable Charge, except when prohibited by law.

Out-of-Network (non-network) health care providers have no agreements with the Plan and are generally free to set their own charges for the services or supplies they provide. The Plan will pay benefits based on the Plan's Maximum Allowable Charge (as defined in the *Key Terms and Definitions*) on non-discounted medically necessary services or supplies, subject to the Plan's Deductibles and Coinsurance. With exception of services subject to the No Surprises Act, Out-of-Network health care providers may bill the participant for any balance that may be due in addition to the amount paid by the Plan (called balance billing). Balance billing for Eligible Medical Expenses can avoided by using In-Network Providers.

Other Providers

If you have a medical condition that the third-party administrator or the utilization management company believes needs special services, they may direct you to a provider identified by them. If you require certain complex covered services for which expertise is limited, the third-party administrator or the utilization management company may direct you to an Out-of-Network provider. In both cases, benefits will only be paid at the In-Network benefit level (subject to the Maximum Allowable Charge) if your covered expenses for that condition are provided by or arranged by the other provider as chosen by third-party claims administrator or the utilization management company.

Participants may obtain health care services from In-Network or Out-of-Network health care providers. Because providers are added and dropped from the PPO network periodically throughout the year, it is the participant's responsibility to verify provider participation before receiving services by contacting the third-party claims administrator at the telephone number or by visiting the provider network's website located at www.pebp.state.nv.us.

Out-of-Network Benefit Exceptions

If there is no In-Network provider within 50-miles of your home, you may be eligible to receive benefits for certain Eligible Medical Expenses paid at the In-Network level, subject to the Plan's Maximum Allowable Charge (with exception of services subject to the No Surprises Act). Benefits that fall under this category must be approved prior to receipt of the care and are subject to any Plan limitations or *Exclusions* set forth in this MPD.

If you are traveling outside your network and you need medical care, you should contact the third-party administrator at the telephone number appearing on your medical identification card for assistance in locating the nearest In-Network provider. If you need emergency care, however, go ahead and get the care you need. The Plan will pay your claim for Eligible Medical Expenses at the In-Network provider level.

Emergency Care

The Plan provides benefits for emergency care when required for stabilization and initiation of treatment as provided by or under the direction of a health care provider. Eligible Medical Expenses that are provided as a result of Emergent care provided by In-Network providers are paid at the In-Network benefit level. Out-of-Network Emergent care for Eligible Medical Expenses are paid at the In-Network benefit level.

Confinement in an Out-of-Network Hospital Following an Emergency

If you are confined in an Out-of-Network hospital after you receive emergency services, the utilization management company must be notified within two business days or on the same day of admission if reasonably possible. The UM company may elect to transfer you to an In-Network hospital as soon as it is medically appropriate to do so. If you choose to stay in the Out-of-Network hospital after the date the utilization management company decides a transfer is medically appropriate, and the provider obtains informed consent and you receive the required notice as required under the No Surprises Act, the Plan will pay Eligible Medical Expenses at the Out-of-Network benefit level, subject to the Plan's Maximum Allowable Charge if the continued stay is authorized by the UM company and determined to be a covered service.

Other Exceptions

If you receive ancillary services such as an x-ray, laboratory services, or anesthesia services from an Out-of-Network provider while receiving services at an In-Network inpatient or outpatient facility (such as an outpatient surgery center), the Plan will cover the *Eligible Medical Expenses* at the In-Network benefit level, subject to the Plan's Maximum Allowable Charge. Services subject to the No Surprises Act are subject to the Recognized Amount.

When Out-of-Network Providers May be Paid as In-Network Providers

When a participant uses the services of an Out-of-Network provider for *Eligible Medical Expenses* in the circumstances defined below, charges by the Out-of-Network provider will be subject to the Plan's Maximum Allowable Charge (as defined in the *Key Terms and Definitions* section).Out-of-Network providers may bill the participant for any balance that may be due in addition to the amount paid by the Plan (called balance billing).

- If a participant traveling to an area serviced by an In-Network provider experiences an urgent but not life-threatening situation and cannot access an In-Network provider, benefits may be paid at the In-Network benefit level for use of an Out-of-Network urgent care facility.
- In the event of a life-threatening emergency in which a participant uses an Out-of-Network urgent care.
- For medically necessary services or supplies when such services or supplies are not available from an In-Network provider within 50 driving miles of the participant's

residence. This includes services provided for wellness/preventive, or a second opinion.

- Participant travels to an area not serviced by an In-Network provider within 50 miles.
- If a participant travels to an area serviced by an In-Network provider, the participant must use an In-Network provider to receive benefits at the In-Network benefit level.
- If there is a specialty not available inside the participant's eligible PPO network, benefits may be paid as In-Network.

Preferred Provider Organizations (PPO Network)

A preferred provider organization (PPO) network is a list of the doctors, other health care providers, and hospitals that the Plan has a contract with to provide medical care for Plan members. These providers are called "network providers" or "In-Network providers."

This Plan includes a PPO network for members residing in-and outside-of Nevada. To locate an In-Network provider visit the PEBP website at www.pebp.state.nv.us or contact the third-party claims administrator. Information regarding the PPO network is also available in the *Participant Contact Guide* section of this document.

Service Area

A "Service Area" is a geographic area serviced by In-Network health care providers. If you and or your covered dependent(s) live more than 50 driving miles from the nearest In-Network health care provider whose services or supplies are determined by the Plan Administrator or its designee as being appropriate for the condition being treated, the Plan will consider that you live outside the service area. In that case, your claim for medically necessary services or supplies from an Out-of-Network health care provider will be treated as if the services or supplies were provided In-Network, subject to the Maximum Allowable Charge.

Directories of Network Providers

Participants are encouraged to confirm the In-Network participation status of a provider prior to receiving services.

A list of PPO providers is available to you without charge by visiting the website or by calling the phone number on your ID card. The network consists of providers, including hospitals, of varied specialties as well as general practice, who are contracted with the Plan or an organization contracting on its behalf.

If you obtain and rely upon incorrect information about whether a provider is a PPO provider from the Plan or its administrators, the Plan will apply PPO cost-sharing to your claim, even if the provider was Non-PPO.

Eligible Medical Expenses

You are covered for expenses you incur for most, but not all, medical services, and supplies. The expenses for which you are covered are called *Eligible Medical Expenses*. Eligible medical expenses are limited to the covered benefits specified in the Schedule of Medical Benefits and are:

- Determined by the Plan Administrator or its designee to be medically necessary (unless otherwise stated in this Plan), but only to the extent that the charges are usual and customary (U&C), provided in-network, and/or do not exceed this Plan's Maximum Allowable Charge (as those terms are defined in the *Key Terms and Definitions* section).
- Not services or supplies that are excluded from coverage (as provided in the *Exclusions* section).
- Charges for services or supplies that do not exceed the Plan Year maximum benefits as shown in the *Schedule of Medical Benefits*.

Generally, the Plan will not reimburse you for all *Eligible Medical Expenses*. Usually, you will have to pay some portion of costs, known as cost-sharing such as Coinsurance toward the amounts you incur for *Eligible Medical Expenses*. However, once you have incurred the Plan Year Out-of-Pocket Maximum cost for *Eligible Medical Expenses*, no further Coinsurance will apply for the balance of the Plan Year. There are also maximum benefits applicable to each participant.

The above is not all inclusive. For more information regarding eligible medical expenses, see the Schedule of Medical Benefits, Key Terms and Definitions, Benefit Limitations and Exclusions sections.

A Person Whose Status Changes from Employee/Retiree to Dependent or from Dependent to Employee

A person who is continuously covered on this Plan before, during, and after a change in status, will be given credit for portions of the medical, prescription drug and dental Deductibles previously met in the same Plan Year, including the benefit maximum accumulators (e.g., medical Out-of-Pocket Maximums, dental frequency maximums and annual benefit maximum) will continue without interruption.

Non-Eligible Medical Expenses

Non-eligible medical expenses are expenses that are excluded from the Plan and do not accumulate towards your Deductible and Out-of-Pocket Maximum.

This Plan does not pay benefits equal to all the medical expenses you may incur. You are responsible for paying the full cost of all expenses that are not *Eligible Medical Expenses*, including expenses that are:

- Not determined to be medically necessary (unless otherwise stated in this Plan).
- Determined to exceed this Plan's Maximum Allowable Charge.
- Expenses for medical services or supplies that are not covered by the Plan, including, but not limited to, expenses that exceed the PPO provider contract rate, services listed in the *Exclusions* section of this document and dental expenses.
- Benefits exceeding those services or supplies subject to limited overall maximums for each covered individual for certain *Eligible Medical Expenses*.
- Additional amounts you are required to pay because of a penalty for failure to comply with the Plan's utilization management requirements described in the *Utilization Management* section of this document. If you fail to follow certain requirements of the Plan's utilization management program, the Plan may pay a smaller percentage of the cost of those services, and you may have to pay a greater percentage of those costs. The additional amount you may have to pay is in addition to your Deductibles or Out-of-Pocket Maximums described in the tables.
- *Preventive Care/Wellness Services* that are paid by the Plan at 100% do not accumulate towards the Out-of-Pocket Maximum.

This list is not all inclusive and may include certain services and supplies that are not listed above.

Non-Eligible Medical Expenses do not accumulate toward the Plan Year Deductible or Out-of-Pocket Maximum as determined by the Plan Administrator for your specific coverage tier. You are responsible for paying these expenses out of your own pocket.

For more information regarding *Non-Eligible Medical Expenses*, see the *Benefit Limitations and Exclusions* section.

PPO Network Health Care Provider Services

If you receive medical services or supplies from an In-Network PPO provider, you will be responsible for paying less money out-of-pocket. Health care providers who are participating providers of the PPO network have agreed to accept the PPO network negotiated amounts in place of their standard charges for covered services. You are responsible for any applicable Plan Deductible and Coinsurance requirements as outlined in this document and are described in more detail in the *Schedule of Medical Benefits*.

With exception of services subject to the No Surprises Act, Out-of-Network providers may bill the participant their standard charges and any balance that may be due after the Plan payment. It is the participant's responsibility to verify the In-Network status of a chosen provider.

NOTE: In accordance with NRS 695G.164, if you are seeing a provider that is In-Network and that provider leaves the network, and you are actively undergoing a medically necessary course of treatment, and you and your provider agree that a disruption to your current care may not be in your best interest or if continuity of care is not possible immediately with another In-Network provider, PEBP will pay that provider at the same level they were being paid while contracted with PEBP's PPO network, if the provider agrees. If the provider agrees to these terms, coverage may continue until:

- The 120th day after the date the contract is terminated; or
- If the medical condition is pregnancy, the 90th day after:
  - The date of delivery; or
  - If the pregnancy does not end in delivery, the date of the end of the pregnancy.

Out-of-Country Medical, Prescription and Vision Purchases

This Plan provides you with coverage worldwide. Whether you reside in the United States and travel to a foreign country, or if you reside outside of the United States permanently or on a part-time basis, and require medical, prescription drug, or vision care services, you may be eligible for reimbursement of the cost.

Please contact this Plan's third-party claims administrator and pharmacy benefit manager before traveling or moving to another country to discuss any criteria that may apply to a medical, prescription drug, or vision service reimbursement request.

Typically, foreign countries do not accept payment directly from the Plan. You may be required to pay for medical and vision care services and submit your receipts to this Plan's third-party claims administrator for possible reimbursement. Medical and vision services received outside of the United States are subject to Plan provisions, coverage, limitations, exclusions, clinical review if necessary, and determination of medical necessity. The review may include regulations determined by the FDA. Out-of-country medication purchases are only eligible for reimbursement while traveling outside of the United States.

The third-party claims administrator may require a written notice from you or your designated representative explaining why you received the medical services from an out of country provider and why you were unable to travel to the United States for these services. This provision applies to elective and emergency services.

Prior to submitting receipts from a foreign country to this Plan's third-party claims administrator, you must complete the following: Proof of payment from you to the provider of service (typically your credit card invoice).

- Itemized bill to include complete description of the services rendered and admitting diagnosis(es).

- Itemized bill must be translated to English.
- Reimbursement request converted to United States dollars.
- Foreign purchases of medical care and services are subject to Plan limitations such as:
  - Benefit coverage
  - Coinsurance and deductibles
  - Frequency maximums
  - Annual benefit maximums
  - Medical necessity
  - FDA approval
  - the Plan's Maximum Allowable Charge

The Plan administrator and the third-party claims administrator reserve the right to request additional information. If the provider will accept payment directly from the claim's administrator, you must also provide the following:

- Assignment of benefits signed by you or an individual with the authority to sign on your behalf such as a legal guardian or Power of Attorney (POA).

Once payment is made to you or to the out-of-country provider, the Plan administrator and its vendors are released from any further liability for the out-of-country claim. The Plan administrator has the exclusive authority to determine the eligibility of all medical services rendered by an out-of-country provider. The Plan administrator may or may not authorize payment to you or to the out-of-country provider if all requirements of these provisions are not satisfied.

This Plan may provide certain benefits for travel assistance back to the United States.

This Plan may provide benefits for the purposes of emergency medical transportation only. For more information, contact this Plan's third-party claims administrator listed in the *Participant Contact Guide*.

Health Savings Accounts

Active **Employees Only**

The Consumer Driven Health Plan (CDHP) is an IRS qualified High Deductible Health Plan. This means the CDHP complies with federal requirements regarding Deductibles, Out-of-Pocket Maximums, and certain other features. As a qualified High Deductible Health Plan, the CDHP is coupled with a Health Savings Account (HSA). A Health Savings Account is a tax-exempt account that you can use to pay or reimburse yourself for certain medical expenses you incur.

HSAs are employee-owned accounts, meaning the funds in the HSA remain with the employee and carry over from one year to the next (i.e., will not be forfeited unless there is no account activity for a 3-year period then the funds will be considered abandoned per NRS 120A.500). Contributions to the HSA grow tax free and are portable. When an employee retires or terminates employment, the employee retains the funds in the HSA. The employee can continue to use the funds in the HSA for health care and other qualified medical expenses after employment ends.

There are limits on the amount an eligible individual can contribute to an HSA based on the employee's coverage tier. For example, "self-only" or "Family" coverage.

- Self-only coverage means an eligible individual (employee).
- Family coverage means an eligible employee covering at least one dependent (whether that dependent is an eligible individual (for example, if the dependent has Medicare) if that other person is claimed on your tax return and not claimed as a tax dependent on someone else's return.

You must be an eligible individual to qualify for an HSA. Employees may <u>not</u> establish or contribute to a Health Savings Account if any of the following apply:

- The employee is covered under other medical insurance coverage unless that medical insurance coverage: (1) is also a High Deductible Health Plan as defined by the IRS; (2) covers a specific disease state (such as cancer insurance); or (3) only reimburses expenses after the Deductible is met.
- The employee is enrolled in Medicare.
- The employee is enrolled in Tricare.
- The employee is enrolled in Tribal coverage.
- The employee can be claimed as a dependent on someone else's tax return unless the employee is Married Filing Jointly.
- The employee or the employee's spouse has a Medical Flexible Spending Account (excludes Dependent Care or Limited Use Flexible Spending Accounts) that can reimburse the employee's medical expenses.
- The employee's spouse has an HRA that can be used to pay for the medical expenses of the employee.
- The employee is on COBRA; or
- The employee is retired.

If an employee loses eligibility to contribute to a Health Savings Account (HSA) for any reason, the Plan reserves the right to cease processing employee contributions to the HSA for the remainder of the Plan Year. If an HSA ineligible employee elects to continue coverage in the Plan for the subsequent Plan Year, the employee will only be eligible to enroll in the Health Reimbursement Arrangement (HRA) to receive PEBP contributions as described below. The HSA third-party claims administrator reserves the right to verify Medicare eligibility with the Centers for Medicare and Medicaid Services (CMS).

Employees who wish to establish or contribute to an HSA should contact the HSA third-party claims administrator regarding eligibility requirements, consult with a tax professional or read the provisions described in IRS Publication 969.

Current CDHP participants who are eligible for the HSA will receive PEBP contributions during the first month of the new Plan Year. New hires receive a prorated contribution based on the coverage effective date and the number of months remaining in the Plan Year. HSA funds may not be used for a person who does not meet the IRS definition of dependent, including many domestic partners, children of domestic partners and older children who cannot be claimed on the participant's tax return, regardless of whether the dependent is covered under this Plan. In general, HSA funds may not be used to pay premiums. There are certain exceptions for retirees or former employees enrolled in a Plan offered under COBRA provisions.

HSA funds may only be used to pay, or reimburse expenses incurred after the HSA is established and can only be reimbursed if there are available HSA funds in the account.

HSA Bank, a division of Webster Bank, N.A., is the third-party claims administrator and custodian for the HSA. PEBP does not (i) endorse HSA Bank, a division of Webster Bank, N.A. as an HSA provider; (ii) limit an employee's ability to move funds to other HSA providers, (iii) impose conditions on how HSA funds are spent, (iv) make or influence investment decisions regarding HSA funds, or (v) receive any payment or compensation in connection with an HSA. PEBP HSA contributions and employee voluntary pre-tax payroll deductions will only be deposited to an HSA at HSA Bank, a division of Webster Bank, N.A. Employees may choose to establish an HSA with any HSA trustee or custodian and may transfer funds deposited into HSA Bank, a division of Webster Bank, N.A. account to another HSA account held by another trustee or custodian. However, PEBP will not pay any fees associated with any other HSA account including transfer fees.

The IRS requires any person with an HSA to submit form 8889 with their annual income tax return.

Health Savings Account Owner Identity Verification

Section 326 of the USA PATRIOT Act requires financial institutions to verify the identity of each employee who opens a Health Savings Account (HSA). If an employee's identity cannot be verified, the employee will be required to provide additional documentation to establish their identity. If additional verification is not provided within 90 days of the employee's HSA opening date, the HSA will be closed. Failure to comply with the identity verification requirement within

the stated timeframe will result in the conversion from an HSA to a Health Reimbursement Arrangement (HRA) for the remainder of the Plan Year. The next opportunity to establish an HSA will be during the Open Enrollment Period for the subsequent Plan Year.

HSA Contributions for Eligible Active Employees	
Active Employees	**Contribution**
Participant Only	***$600**

*HSA contribution provided to HSA eligible active employees enrolled in the CDHP on **July 1, 2023**. New hires with benefits effective **August 1, 2023,** and later receive a pro-rated contribution based on their CDHP coverage effective date. For **Plan Year 2024**, dependents are not eligible for a PEBP HSA contribution. Under no circumstances will a participant who received contributions during the Plan Year be eligible for additional contributions due to reinstatement of coverage or changing from the CDHP with an HSA to the CDHP with a HRA or vice versa.

Calendar Year 2023 HSA Contribution Limits	
Individual	**Family** (two or more HSA eligible family members)
$3,850	**$7,750**
Total contributions (combined employee/employer) cannot exceed the **2023 calendar year limit**. To contribute the family maximum, the employee and at least one tax dependent must be covered on the CDHP Plan. The Family maximum applies regardless of whether two employees are married and enrolled in the CDHP and eligible for the HSA. For example, if one employee is covering an HSA eligible dependent and the other employee is covered as self-only, the maximum for the entire family is **$7,750**. Employees aged 55 years and older at the end of the tax year may contribute an additional **$1,000** to the HSA.	

Calendar Year 2024 HSA Contribution Limits	
Individual	**Family** (two or more HSA eligible family members)
$-pending-	**$-pending-**
Total contributions (combined employee/employer) cannot exceed the **2024 calendar year limit**. To contribute the family maximum, the employee and at least one tax dependent must be covered on the CDHP Plan. The Family maximum applies regardless of whether two employees are married and enrolled in the CDHP and eligible for the HSA. Employees aged 55 years and older at the end of the tax year may contribute an additional ***$1,000*** to the HSA.	

Health Reimbursement Arrangement

PEBP and its vendor require direct deposit for HRA reimbursements.

Active Employees and Retirees

This section provides summary information only. For more detailed information regarding this important benefit, see Internal Revenue Service (IRS) Publication 502 or contact the HRA third-party claims administrator listed in the *Participant Contact Guide*.

The CDHP with an HRA is available to active employees who are not eligible for an HSA, or who fail to establish an HSA, it is also available to eligible retirees enrolled in the CDHP.

Each Plan Year, PEBP contributions will be available for use through a CDHP HRA account established in the employee's or retiree's name. Funds in the CDHP HRA account may be used, tax-free, to pay for qualified medical expenses as defined by the IRS (see IRS Publication 502), other than premiums, including payment of Deductibles, Coinsurance, and other Out-of-Pocket qualifying healthcare expenses not covered by this Plan.

The CDHP's HRA may only be used to pay or reimburse qualified Out-of-Pocket health care expenses incurred by:

- the participant; or
- the participant's spouse; or
- participant's dependent(s) who could be claimed on the participant's annual tax return;

CDHP HRA funds may not be used for a person who does not meet the IRS definition of a qualified tax dependent, including many domestic partners, children of domestic partners and older children who cannot be claimed on the participant's tax return, regardless of whether PEBP provides coverage for the dependent.

The entire annual PEBP base contribution for **Plan Year 2024** will be available for use at the beginning of the Plan Year on or about **July 1, 2023** (subject to certain limitations). Participants who initially ~~become eligible~~ elect for PEBP coverage after **July 1, 2023**, will receive a pro-rated base contribution for the participant based upon the coverage effective date and the months remaining in the Plan Year. Participants cannot contribute to a CDHP HRA. If the annual funds in the CDHP HRA are exhausted, neither PEBP nor the participant will contribute any additional funds.

Participants are allowed the option annually, and at termination in the plan, to permanently opt-out of the HRA, and thereby forfeit any unused balance.

Any funds remaining in the CDHP HRA at the end of the Plan Year will carryover (i.e., will not be forfeited) and will be available for use in the following Plan Year. Unlike a Flexible Spending Account (FSA), participants cannot be reimbursed from funds that are not yet available in the

CDHP HRA. Any reimbursement from the CDHP HRA will be the lesser of the available CDHP HRA balance or the claim amount paid to the provider.

CDHP HRA funds are not portable; participants cannot use CDHP HRA funds if they are no longer covered by the CDHP HRA. If a participant terminates their CDHP coverage, the remaining balance in the CDHP HRA account will revert to PEBP, unless the qualified beneficiary elects COBRA. Participants enrolled in the CDHP HRA who change plans during the Open Enrollment period to a plan without a HRA or Health Plan of Nevada, and retirees who transition coverage to the Via Benefits Medicare exchange will forfeit any remaining funds in their CDHP HRA account.

Active employees who retire and who are not Medicare age (typically at age 65 years) can maintain the balance of their CDHP HRA account at retirement if:

- They are eligible to enroll in and continue coverage under the CDHP plan; or
- Continue CDHP coverage under COBRA.
    - If a participant elects COBRA coverage, the CDHP HRA account will remain in place until COBRA coverage is terminated.

In the case of a retroactive coverage termination, any funds used from the CDHP HRA for expenses that are incurred after the date of coverage termination will be recovered by PEBP through the collection process.

Retirees who have a CDHP HRA balance and who transition to the Medicare Exchange will forfeit any remaining funds in the HRA on the last day of coverage under the Plan.

The death of an active employee or retiree will cause any remaining funds in the HRA to be forfeited on the first day following the date of death.

Timely Filing of HRA Claims

In accordance with NAC 287.610, all claim requests must be submitted to the third-party claims administrator within one year (12 months) from the date of service that the claim is incurred. No plan benefits will be paid for any claim requests submitted after this period.

When your HRA-eligible coverage ends, you will have one year (12-months) from the date your coverage ends to file a claim for reimbursement from your HRA for eligible claims incurred during your coverage period in accordance with NAC 287.610, dependent on the date of service. CDHP HRA funds may not be used to pay premiums.

HRA Contributions for Eligible Active Employees and Retirees

Employee/Retiree	Contribution
Participant Only	***$600**

*HRA contribution provided to eligible active employees/retirees enrolled in this Plan on **July 1, 2023**. For **Plan Year 2024**, dependents are not eligible for PEBP HRA contributions. New hires effective **August 1, 2023,** and later receive a pro-rated contribution based on their CDHP coverage effective date.

Under no circumstances will a participant who received contributions during the Plan Year be eligible for additional contributions due to reinstatement of coverage or changing from the CDHP with an HSA to the CDHP with a HRA or vice versa.

Reinstated employees who return to active employment within the same Plan Year and who re-enroll in the CDHP HRA shall have their remaining HRA fund balance reinstated. Reinstated employees who re-enroll in the CDHP HRA more than one year after termination are not eligible for reinstatement of HRA balance reinstatement. No additional prorating of HRA funds is available to reinstatements unless the reinstated employee is eligible for additional prorated funding due adding new dependent(s).

One-Time HSA or HRA Funding

PEBP will provide additional funding for the HSA or HRA for active employees enrolled in the CDHP on July 1, 2023. **This is a one-time event.**

The entire annual PEBP one-time contribution for **Plan Year 2024** will be available for use at the beginning of the Plan Year on or about **July 1, 2023** (subject to certain limitations, above).

HRA Contributions for Eligible Active Employees and Retirees	
Employee	**One-Time Contribution**
Participant Only	***$300**

*One-time contribution provided to eligible active employees enrolled in the CDHP HSA/HRA on **July 1, 2023**. Participants who initially elect PEBP coverage after July 1, 2023, will receive a pro-rated base contribution for the participant based upon the coverage effective date and the months remaining in the Plan Year. ~~New hires effective **August 1, 2023,** and later will not receive a pro-rated contribution based on their CDHP coverage effective date.~~

Utilization Management

The Plan is designed to provide you and your eligible dependents with financial protection from significant health care expenses. To enable the Plan to provide coverage in a cost-effective way, it has a Utilization Management (UM) program designed to help control increasing health care costs by avoiding unnecessary services, directing participants to more cost-effective treatments capable of achieving the same or better results and managing new medical technology and procedures. If you follow the procedures of the Plan's UM program, you may avoid some Out-of-Pocket costs. However, if you do not follow these procedures, Plan benefits may be reduced, and you will be responsible for paying more out of pocket.

The Plan's UM program is administered by an independent professional UM company operating under a contract with the Plan. The name, address and telephone number of the UM company appears in the *Participant Contact Guide* section. The health care professionals at the UM company focus their review on the medical necessity of hospital stays and the medical necessity, appropriateness, and cost-effectiveness of proposed medical or surgical services. In carrying out its responsibilities under the Plan, the UM company has been given discretionary authority by the Plan administrator to determine if a course of care or treatment is medically necessary with respect to the patient's condition and within the terms and provisions of the Plan.

The UM program is not intended to diagnose or treat medical conditions, validate eligibility for coverage, or guarantee payment of Plan benefits. Eligibility for and actual payment of benefits are subject to the terms and conditions of the Plan as described in this document, PEBP's *Employee Health and Welfare Wrap Plan, and Retiree Health and Welfare Wrap Plan* documents. For example, benefits would not be payable if your eligibility for coverage ended before the services were rendered, or if the services were not covered, either in whole or in part, by an exclusion in the Plan.

Regardless of whether your physician recommends surgery, hospitalization, confinement in a skilled nursing or sub-acute facility, or your physician or other provider proposes or provides any medical service or supply, does not mean the recommended services or supplies will be considered medically necessary for determining coverage under the Plan.

Benefits payable by the Plan may be affected by the determination of the UM company if
The UM company does not authorize a proposed surgery or other proposed medical treatment as medically necessary; or

- The Plan will not pay regular benefits for a hospitalization or confinement in a skilled nursing or sub-acute facility because the UM company does not authorize a proposed confinement.

PEBP, the third-party claim administrator, and the UM company are not engaged in the practice of medicine and are not responsible for the outcomes of health care services rendered (even if the health care services have been authorized by the UM company as medically necessary), or

for the outcomes if the patient chooses not to receive health care services that have not been authorized by the UM company as medically necessary.

When reviewing services for appropriateness of care and medical necessity, the UM company uses guidelines and criteria published by nationally recognized organizations, along with medical judgement of licensed heath care professionals.

Delivery of Services

You are entitled to receive medically necessary medical care and services as specified in this Plan's *Schedule of Medical Benefits*. These include medical, mental health, behavioral health, surgical, diagnostic, therapeutic, and preventive services. If a precertification is required and you do not obtain the required precertification, the service may not be covered, even if the service is medically necessary. These services, although not all inclusive are those that generally:

- Are provided In-Network and Out-of-Network,
- Are performed or ordered by a participating provider,
- Require a precertification according to the utilization management and quality assurance protocols, if applicable.

Concurrent Review

Concurrent Review (continued stay) is the ongoing assessment of the health care as it is being provided, especially (but not limited to) inpatient confinement in a hospital or skilled nursing or sub-acute facility. When you are receiving medical services in a hospital or other inpatient facility, the UM company monitors your stay by contacting your physician or other providers to assure that continuation of medical services in the facility is medically necessary. The UM company will also help coordinate your medical care with other healthcare benefits available under the Plan.

Concurrent review may include such services as coordinating home health care or durable medical equipment, assisting with discharge plans, determining the need for continued medical services, and or advising your physician or other providers of various options and alternatives for your medical care available under this Plan.

If at any point, your stay is found not to be medically necessary and care could be safely and effectively delivered in another environment (such as through home health care or in another type of health care facility), you and your physician will be notified. This does not mean that you must leave the hospital, but if you choose to stay, all expenses incurred after the notification will be your responsibility. If your hospital stay is determined not to be medically necessary, no benefits will be paid on any related hospital, medical or surgical expense. You may also appeal the determination (refer to the *Appealing a UM determination* section).

Retrospective Review

Retrospective Review is the review of health care services after they have been provided to determine if those services were medically necessary. The Plan will pay benefits only for those

days or treatment that would have been authorized under the utilization management program; and case management: The process whereby the patient, the patient's family, physician, or other providers work together with the Plan Administrator or its designee under the guidance of the UM company to coordinate a quality, timely and cost-effective treatment plan.

Case Management

Case management is a voluntary process administered by the UM company. Its medical professionals work with the patient, the patient's family, caregivers, providers, the third-party claims administrator, and the Plan Administrator or its designee to coordinate a timely and cost-effective treatment program. Case management services are particularly helpful when the patient needs complex, costly and/or high-technology services, or when assistance is needed to guide the patient through a maze of potential providers. Case management is available for sickle cell disease, among other conditions (NRS 695G.174).

The case manager will work directly with your physician, hospital, and/or other provider to review proposed treatment plans and to assist in coordinating services and obtaining discounts from providers as needed. From time to time, the case manager may confer with your physician or other providers and may contact you or your family to assist in making plans for continued health care services or obtaining information to facilitate those services.

You, your family, or your physician may call the case manager at any time to ask questions, make suggestions or offer information. The case manager can be reached by calling the UM company at the telephone number shown in the *Participant Contact Guide* section or on the PEBP website at www.pebp.state.nv.us.

Precertification (Prior Authorization) Process

Precertification prior authorization review is a procedure administered by the UM company to assure health care services meet or exceed accepted standards of care. In certain cases, as set forth below, for a benefit to be covered, the UM company must approve and/or pre-certify the service**. If a precertification is required and you do not obtain the required precertification, the benefits may be reduced, even if the service is medically necessary.** The UM company uses nationally recognized guidelines and criteria as standard measurement tools to determine whether benefits are approved and/or pre-certified.

Precertification also includes the determination of whether the admission and length of stay in a hospital or skilled nursing or sub-acute facility, surgery or other health care services are medically necessary and if the location of service is high quality and lowest cost.

A precertification is required for referrals to physicians and providers for certain services. All benefits listed in this Plan may be subject to precertification requirements and concurrent or retrospective review depending upon the circumstances associated with the services. Refer to the Services Requiring Precertification section below for more information.

Failure to obtain precertification may result in your benefits being reduced or denied (see the *Failure to Follow Required Utilization Management Procedures* in this section).

Services Requiring Precertification (Prior Authorization)

All Inpatient Admissions

- Acute; observation; and same day surgeries
- Long-Term Acute Care
- Rehabilitation
- Behavioral Health
- Transplant including all pre-transplant related expenses
- Skilled Nursing facility and sub-acute facility
- Residential Treatment Facility, including outpatient partial hospitalization programs, and partial residential treatment programs
- Hospice (inpatient/outpatient) exceeding 185 days
- Obstetric – (precertification only required if days exceed 48 hours for vaginal delivery or 96 hours for a C-section)
- Intraoperative Neuro Monitoring

Outpatient and Physician - Surgery

- Back Surgeries and hardware related to surgery
- Total and remaining Hip and Knee Surgeries
- Biopsies (excluding skin, colonoscopy and upper GI endoscopy biopsy, upper GI endoscopy diagnosis)
- Thyroidectomy, Partial or Complete
- Open Prostatectomy
- Frenectomy
- Oophorectomy, unilateral and bilateral
- Hysterectomy (including prophylactic)
- Autologous chondrocyte implantation, Carticel
- Transplant (excluding cornea)
- Balloon sinuplasty
- Surgeries to treat Gender Dysphoria
- Bariatric/weight loss surgeries at Centers of Excellence and adjustments to lap bands after the first 12 months post-surgery
- Sleep apnea related surgeries, limited to:
    - Radiofrequency ablation (Coblation, Somnoplasty)
    - Uvulopalatopharyngoplasty (UPPP) (including laser-assisted procedures)
- Mastectomy (including gynecomastia and prophylactic) and reconstruction surgery
- Orthognathic procedures (e.g., Genioplasty, LeFort osteotomy, Mandibular ORIF, TMJ)
- Varicose vein surgery/sclerotherapy

- Any procedure deemed to be Experimental and/or Investigational (provider must indicate on the pre-certification request that the service/procedure is Experimental and/or Investigational and/or part of a clinical trial).
- Intraoperative Neuro Monitoring
- Prophylactic surgery

Outpatient and Physician – Diagnostic Services

- CT, PET, SPEC, and MRI
- Capsule endoscopy
- Genetic Testing (including BRCA)

Outpatient and Physician – Continuing Care Services

- Applied Behavior Analysis (ABA) Therapy
- Dialysis
- Electroconvulsive Therapy (ECT)
- Transcranial Magnetic Stimulation (TMS)
- Chemotherapy
    - Oral Chemotherapy to be reviewed by Pharmacy Benefit Manager
- Radiation Therapy
- Oncology and transplant related injections, infusions, and treatments (e.g., CAR-T, endocrine and immunotherapy), excluding supportive drugs (e.g., antiemetic and antihistamine)
- Hyperbaric Oxygen
- Home Health Care
- Durable Medical Equipment exceeding $1,000
    - prior authorization is based on overall cost to the plan and/or purchase price, not the amount billed for monthly rental. DME rental to purchase in accordance with Medicare guidelines.
- Non-Emergency Medical Transportation – scheduled air and ground facility to facility and interstate
- Injectables and infusions excluding services reviewed by the PBM
- Behavioral Health Intensive Outpatient Program
- Sickle Cell Disease
- Vein Therapy
- Electroconvulsive Therapy (ECT)
- Transcranial Magnetic Stimulation (TMS)
- Habilitative and rehabilitative therapy (physical, speech, occupational) exceeding a combined visit limit of 90 visits per Plan Year

Services Not Requiring Precertification (Prior Authorization)

Prior authorization is not required for medically necessary emergency services when a medical condition that manifests itself by symptoms of such severity (including severe pain) that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect that the absence of immediate medical attention could result in:

- Serious jeopardy to the health of the participant.
- Serious jeopardy to the health of an unborn child.
- Serious impairment of a bodily function; or
- Serious dysfunction of any bodily organ or part.

The UM company must be notified of an emergency hospital admission within one business day so the UM company can conduct a *concurrent review*. Your physician or the hospital should call the UM company to initiate the concurrent review. Even though a precertification may not be required for some services, the hospital or facility is still required to comply with the Plan's provisions regarding UM, such as concurrent review.

How to Request Precertification (Prior Authorization)

It is your responsibility to ensure that precertification occurs when it is required by the Plan. Any penalty or denial of benefits for failure to obtain precertification is your responsibility, not the provider's. You or your physician must call the UM company at the telephone number shown in the ***Participant Contact Guide*** to request precertification. Calls for elective services should be made at least 15 calendar days before the expected date of service or may be subject to the benefit reduction listed in the ***Utilization Management*** section. The UM company will require the following information:

- The employer's name.
- Employee's name.
- Patient's name, address, phone number and Social Security Number or PEBP unique ID.
- Physician's name, phone number or address.
- The name of any hospital or outpatient facility or any other provider that will be providing services.
- The reason for the health care services or supplies; and
- The proposed date for performing the services or providing the supplies.

The UM company will review the information and provide a determination to you, your physician, the hospital or other provider, and the third-party claims administrator as to whether the proposed health care services have been determined to be medically necessary. Additionally, the UM company may approve medical necessity but not site of care. In these circumstances, the UM company will provide approved alternate locations to the caller. While industry and accreditation standards require a preauthorization determination within 15 calendar days for a non-urgent case, the UM company will usually respond to your physician or other provider by telephone within (5) five business days of receipt of the request. The determination will then be confirmed in writing.

If your hospital admission or medical service is determined not to be medically necessary, you and your physician will be given recommendations for alternative treatment. You may also pursue an appeal (refer to the *Appealing a UM Determination* section).

Second Opinion

The utilization management company may authorize a second opinion upon your request in accordance with this Plan. Examples of instances where a second opinion may be appropriate include:

- Your physician has recommended a procedure and you are unsure whether the procedure is necessary or reasonable.
- You have questions about a diagnosis or plan or care for a condition that threatens substantial impairment or loss of life, or bodily functions.
- You are unclear about the clinical indications about your condition.
- A diagnosis is in doubt due to conflicting test results.
- Your physician is unable to diagnose your condition; and a treatment plan in progress is not improving your medical condition within a reasonable period.

A participating provider, including your primary care physician, may notify the UM company on your behalf to obtain precertification (prior authorization) for the services described in Services Requiring Precertification (Prior Authorization).

Hospital Admission

You are responsible for ensuring the UM company is notified at least 5 (five) business days before an inpatient admission to obtain pre-certification.

Your physician or other provider may notify the UM company, but it is ultimately your responsibility to make sure they are notified. The UM company will review the physician/provider's recommendation and treatment plan to determine the level of care and place of service. If the UM company denies the precertification for hospital admission as not covered or they determine that the services do not meet the UM company's medical necessity criteria, the Plan's third-party administrator will only pay benefits for inpatient that has been pre-certified.

You are required to obtain a precertification before you obtain services for inpatient elective surgeries. If you do not follow the required UM process, benefits for the elective surgeries may be reduced by 50% of this Plan's Maximum Allowable Charge. This provision applies to both In-Network and Out-of-Network surgery expenses. Expenses related to the penalty will not be counted to meet your Out-of-Pocket Maximum, if applicable.

Emergency and Urgent Hospital Admission

This includes all complications of pregnancy

You are not required to obtain a precertification before you obtain services for a medical emergency. However, the UM company must still be notified within 24 hours, the next business day, or as soon as reasonable after admission so the UM company can conduct a concurrent review. If you are incapacitated and you (or a friend or relative) cannot notify the UM company within the above stated times, they must receive notification as soon as reasonably possible after the admission or you may be subject to reduction or denial of benefits as provided by the Plan.

- Emergency Hospital Admission: Admission for hospital confinement that results from a sudden and unexpected onset of a condition that requires medical or surgical care. In the absence of such care, you could reasonably be expected to suffer serious bodily injury or death. Examples of emergency hospital admission include, but are not limited to, admissions, for heart attacks, severe chest pain, burns, loss of consciousness, serious breathing difficulties, spinal injuries, and other acute conditions.
- An urgent hospital admission means an admission for a medical condition resulting from injury or serious illness that is less severe than an emergency hospital admission but requires care within a short time, including complications of pregnancy.

Even though a precertification may not be required for some services, the hospital or facility is still required to comply with the Plan's provisions regarding utilization management, such as concurrent review.

If you do not follow the required UM process, benefits payable for the services may be reduced by 50% of this Plan's Maximum Allowable Charge. This provision applies to both In-Network and Out-of-Network medical expenses. Expenses related to the penalty will not be counted to meet your Out-of-Pocket Maximum.

Confinement in an Out-of-Network Hospital Following an Emergency Admission

Please refer to the No Surprises Act section of this document for claims subject to that Act. For all other confinements, if you are confined in an Out-of-Network hospital after you receive emergency services, the UM company must be notified within 24 hours, the next business day, or as soon as reasonable after admission. The UM company may determine it is appropriate to transfer you to an In-Network hospital as soon as it is medically appropriate to do so. If you choose to stay in the Out-of-Network hospital after the date the UM company decides a transfer is medically appropriate, the Plan will pay Eligible Medical Expenses at the Out-of-Network benefit level, subject to the Plan's Maximum Allowable Charge if the continued stay is authorized by the UM company and determined to be a covered service.

Other Exceptions

If you receive ancillary services such as an x-ray, laboratory services, or anesthesia services from an Out-of-Network provider while receiving services at an In-Network inpatient or outpatient facility (such as an outpatient surgery center), the Plan will cover the Eligible Medical Expenses at the In-Network benefit level, subject to the Plan's Maximum Allowable Charge.

Elective Knee and Hip Joint Replacement – Nevada Exclusive Hospitals and Outpatient Surgery Centers

Precertification is required; the UM company will review the request based on surgery type, medical necessity, covered benefits, provider quality, cost, and provider location.

Due to cost variations for elective knee and hip joint replacement performed in Nevada, the third-party claims administrator has identified exclusive providers who meet the Plan's cost

threshold for routine knee and hip replacement procedures. The exclusive provider list can be found on the PEBP website.

If you choose a provider on the exclusive list, you will potentially reduce your out-of-pocket costs in accordance with the standard plan benefits.

However, if you choose to use a non-exclusive provider, the Plan will pay benefits in accordance with its cost threshold or Maximum Allowable Charge. You may be subject to balance billing for any amount exceeding this Plan's cost threshold. Amounts exceeding the Plan's established threshold will not apply to your Deductible (if applicable) or Out-of-Pocket Maximum.

Inpatient or Outpatient Surgery

You are responsible for ensuring that the UM company is notified at least 5 (five) business days before elective inpatient or outpatient surgery is performed to ensure that it is covered.

Your physician or other provider may notify the UM company, but it is your responsibility to make sure they are notified. The UM company will review the physician's recommended course of treatment to ensure the requested treatment meets established medical necessity criteria and protocols.

The claims administrator will only pay benefits for inpatient or outpatient surgery that is pre-certified, and the services/supplies are a covered benefit.

Outpatient Infusion Services

Precertification is required for outpatient infusion services. The UM company will review the request based on covered benefits, medical necessity, provider quality, cost, and location. If you choose to receive your infusion at a non-exclusive hospital or infusion center, you will be responsible for any amount that exceeds this Plan's Maximum Allowable Charge. Amounts exceeding this Plan's established cost threshold will not apply to your annual Deductible or Out-of-Pocket Maximum.

Air/Flight Schedule Inter-Facility Transfer

All inter-facility transport services require precertification. The UM company may discuss with the physician and/or hospital/facility the diagnosis and the need for inter-facility patient transport versus alternatives. Failure to obtain a precertification may result in a reduction or denial of benefits for charges arising from or related to flight-based inter-facility transfers. Non-compliance penalties imposed for failure to obtain a precertification will not be included as part of the annual out-of-pocket maximum.

Inter-facility transport may occur if there is a life-threatening situation, or the transport is deemed medically necessary. The following conditions apply:

- Services via any form of air/flight for inter-facility transfers must be pre-certified before transport of the participant to another hospital or facility, and the

participant is in a hospital or other health care facility under the care or supervision of a licensed health care provider; and
- Inaccessibility to ground ambulance transport or extended length of time required to transport the patient via ground ambulance transportation could endanger the patient.

Emergency Air Ambulance

This Plan provides coverage for emergency air ambulance transportation for participants whose medical condition at the time of pick-up requires immediate and rapid transport due to the nature and/or severity of the illness/injury. Air ambulance transportation must meet the following criteria:

- Services via any form of air/flight for emergency air ambulance; and
- The patient's destination is an acute care hospital; and
- The patient's condition is such that the ground ambulance (basic or advanced life support) would endanger the patient's life or health; or
- Inaccessibility to ground ambulance transport or extended length of time required to transport the patient via ground ambulance transportation could endanger the patient.

See Air Ambulance Services for details on plan benefits and coverage.

Gender Dysphoria -Related Services

The participant or their physician must contact the UM company to begin the process toward surgical intervention of gender dysphoria. The initial contact will include:

- Notification to the participant that the precertification process begins with the initial contact to the UM company.
- Coverage for procedures are based on the UM company's clinical policy for medical necessity and
- Advising participants of providers who specialize in this type of treatment.

This service is provided by the UM company and will be initiated upon the first call for a precertification. Case management services are particularly helpful for a participant or their covered dependent who is receiving complex medical services for medical conditions such as gender dysphoria. Your assigned case manager nurse will provide you with assistance with addressing any concerns you may have about issues such as, continuity of care or finding providers or a provider who specializes in gender dysphoria.

Health Care Services and Supplies Review

A participating provider, including your primary care physician, may notify the UM company on your behalf to obtain precertification (prior authorization) for the services described in *Services Requiring Precertification (Prior Authorization).*

Non-participating providers may not know the UM company to obtain precertification for services. In such a case, you must confirm that the UM company pre-certified the service to assure that it is covered.

The Plan will pay for covered health care services and supplies only if authorized as outlined above. The Plan will not pay for any health care services or supplies that are not covered services or do not meet medically necessary criteria and protocols.

Failure to Follow Required UM Procedures

If you do not follow the required precertification review process described in this section, benefits payable for the services you failed to receive a precertification may be reduced by 50% of the Plan's Maximum Allowable Charge. This provision applies to both In-Network and Out-of-Network *Eligible Medical Expenses*. Expenses related to the penalty will not apply to your Plan Year Deductible or Out-of-Pocket Maximum. If you wish to appeal a decision made by the UM company, refer to the *Appealing a UM Determination* section.

Coronavirus (COVID-19) Benefits

Benefit Description

COVID-19 Plan Benefits

Coronavirus Aid, Relief, and Economic Security Act (CARES Act) (see *Key Terms and Definitions*) Benefits apply during the Coronavirus Pandemic unless otherwise mandated by federal or state law, or as stated below in the Explanations and Limitations.

Explanations and Limitations

Coronavirus (COVID-19) Pandemic Benefits

The following benefits will be paid at 100% of the Maximum Allowable Charge, both, In-and Out-of-Network during the national public health emergency period.

- **COVID-19 Diagnostic Testing:** virus/antigen detection (diagnostic) test determines if a person is currently infected with COVID-19. An antibody (serology) test may determine if a person may have been infected with the virus, and according to the FDA, antibody tests should not be used to diagnose current infection.
    - Medically appropriate, FDA-authorized, COVID-19 testing when ordered by a physician or health care professional for purposes of diagnosis or treatment.
    - Diagnostic testing is different than COVID-19 screening/surveillance testing.
- **COVID-19 Related Diagnostic Testing Visit:** COVID-19 testing related visits such as urgent care, emergency room, physician's office, telemedicine, and telehealth visits.
- **COVID-19 Preventive Health Services:** In accordance with the following, the Plan covers qualifying coronavirus disease 2019 (COVID-19) preventive services at 100% of the Plan's Maximum Allowable Charge for In-Network and Out-of-Network providers without any cost sharing (Copayment, Deductible, or Coinsurance):
    - An evidence-based item or service that has in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; or (B) An immunization that has in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC).
- **Laboratory Services Related to Covid-19**
    - COVID-19 Diagnostic Testing: virus/antigen detection (diagnostic) test determines if a person is currently infected with COVID-19. An antibody (serology) test may determine if a person may have been infected with the virus, and according to the FDA, antibody tests should not be used to diagnose current infection. Covid-19 Diagnostic Testing will be paid at 100% of the Maximum Allowable Charge, both, In-and Out-of-Network in accordance with the CARES Act or until the last date of the national public health emergency period.
    - COVID-19 Screening/Surveillance Testing**:** COVID testing conducted for purposes other than diagnostic (including, but not limited to, employer mandated, travel, social/entertainment purposes) is not a covered benefit.

All benefits are subject to cost-sharing unless otherwise stated.

Schedule of Medical Benefits

The *Schedule of Medical Benefits* provides a description of benefits, including certain limitations under this Plan. All covered services must be medically necessary and are subject to exclusions and limitations as described herein. Precertification is required for many services, plan benefit limitations apply to certain benefit categories, and out-of-network are not covered unless otherwise specified in this document.

When the Plan Administrator determines that two or more courses of treatment are substantially equivalent, the Plan Administrator reserves the right to substitute less costly services or benefits for those that this Plan would otherwise cover.

> *Example: If both inpatient care in a skilled nursing facility and intermittent, part-time nursing care in the home would be medically appropriate, and if inpatient nursing care would be less costly, this Plan could limit coverage to the inpatient care. This Plan could limit coverage to inpatient care even if this means extending the inpatient benefit beyond the quantity provided in the Schedule of Medical Benefits.*

The fact that a participating provider prescribed, ordered, recommended, or approved a service, treatment, or supply does not necessarily make it a covered service or medically necessary.

The *Schedule of Medical Benefits* should be read in conjunction with the *Benefit Limitations and Exclusions* and *Key Definitions Terms and Definitions*. the Explanations and Limitations may not include every limitation. For more information relating to a specific benefit, refer to *Utilization Management* (for any precertification requirements), *Exclusions*, *Key Terms and Definitions* and other sections that may apply to a specific benefit.

All claims must be submitted within twelve (12) months of the date of service to be considered for payment.

The following services are covered services when provided by a professional.

Benefit Description	In-Network	Out-of-Network
Acupuncture and Acupressure	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible
Explanations and Limitations Acupuncture and Acupressure • Covered if performed by a licensed provider acting within the scope of their license. • Supporting documentation establishing medical necessity will be required after 20 visits in a Plan		

Benefit Description	In-Network	Out-of-Network
Year, maximum 100 visits per lifetime. • Maintenance services are not a covered benefit.		
Allergy Services	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible, or 110% of the Medi-Span Average Wholesale Price (AWP) after Plan Year Deductible
Explanations and Limitations Allergy Services • Allergy services are covered only when ordered by a physician. • Allergy sensitivity testing, including skin patch or blood tests such as Rast or Mast; Desensitization and hypo-sensitization (allergy shots given at periodic intervals); Allergy antigen solution.		

Benefit Description	In-Network	Out-of-Network
Ambulance		
Ground Ambulance	Plan pays 80% after Plan Year Deductible	Play pays 80% of Maximum Allowable Charge after Plan Year Deductible
Air Ambulance	Plan pays 80% after Deductible	Plan pays 80%, subject to the No Surprises Act.
Explanations and Limitations Ground and Air Ambulance Services Ground Ambulance Services: In the event of a life-threatening emergency in which a participant uses an Out-of-Network provider, benefits will be paid at the In-Network benefit level, subject to the Plan's Maximum Allowable Charge. Out-of-Network providers do not have a contract with this Plan's provider network and may balance bill the member for any amounts exceeding the Plan's Maximum Allowable Charge as defined in the section. Air Ambulance Services: In the event of a life-threatening emergency in which a participant uses an Out-of-Network provider, benefits will be paid at the In-Network benefit level. Out-of-Network providers do not have a contract with this Plan's provider network and may not balance bill the member. Transportation by a professional ground ambulance to a local hospital or transfer to the nearest facility having the capability to treat the condition.		

Air Ambulance (fixed wing/rotary) Inter-Facility Transfer

- Inter-facility patient air transport, for participants if there is a life-threatening situation or it is deemed to be medically necessary.
- Air ambulance for scheduled inter-facility transfers must be prior authorized before transport via any form of flight (fixed wing/rotary) to another hospital or facility.
  - Failure to obtain a precertification may, at the discretion of the Plan Administrator or its designee, result in a reduction or denial of benefits for charges arising form or related to inter-facility patient transport via any form of flight.
  - Non-compliance penalties imposed for failure to obtain precertification will not apply to the Plan Year Deductible or Out-of-Pocket Maximum.
  - As part of the precertification review, the Plan Administrator retains the discretionary authority to limit benefit availability to alternative providers of flight-based inter-facility patient transport if a provider fails to comply with the terms of the Plan, or the proposed charges exceed the maximum allowable charge in accordance with the terms of this Plan.

Air Ambulance (fixed wing/rotary) Emergency

- Includes coverage for emergency air ambulance transportation when a medical condition at the time of pick-up requires immediate and rapid transport due to the nature and/or severity of the illness/injury.
- Emergency air ambulance services must meet the following criteria:
  - The patient's destination is an acute care hospital, and
  - The Patient's condition is such that the ground ambulance (basic or advanced life support) would endanger the patient's life or health, or
  - Inaccessibility to ground transport or extended length of time required to transport the patient via ground ambulance transportation could endanger the patient.
- The Plan Administrator retains the discretionary authority to limit benefit availability for air emergency ambulance and/or inter-facility patient transfer when a provider fails to comply with the terms of this Plan, except where provided by the No Surprises Act.

See the *Utilization Management* section for air ambulance precertification requirements.

Benefit Description	In-Network	Out-of-Network
Autism Spectrum Disorders Services	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible

Explanations and Limitations

Autism Spectrum Disorders Services

The Plan provides benefits for autism spectrum disorders in accordance with NRS 695G.1645 , including coverage of screening for and diagnosis of autism spectrum disorders and for the treatment of autism spectrum disorders for covered individuals.

Benefit Description	In-Network	Out-of-Network
Autism Spectrum Disorders Services	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible

Explanations and Limitations
Autism Spectrum Disorders Services

Treatment of autism spectrum disorders must be identified in a treatment plan and may include medically necessary habilitative or rehabilitative care, prescription drug care, psychiatric care, psychological care, behavioral therapy, or therapeutic care that is:

- Prescribed for a person diagnosed with an autism spectrum disorder by a licensed physician or licensed psychologist; and
- Provided for a person diagnosed with an autism spectrum disorder by a licensed psychologist, licensed behavior analyst or other provider that is acting within the scope of their license.

Excludes coverage for reimbursement to an early intervention agency or school for services delivered through early intervention or school services.
Terms in the Autism Spectrum Disorders section of NRS have the definitions assigned to them in NRS 689B.0335 and not necessarily the definitions in this MPD.

Benefit Description	In-Network	Out-of-Network
Bariatric/Weight Loss Surgery	Plan pays 80% after Plan Year Deductible	Not Covered

Explanation and Limitations
Bariatric/Weight Loss Surgery

Bariatric weight loss surgery benefits, pre-and post-surgery, are available only when performed at an In-Network Bariatric Surgery Center of Excellence facility, by an In-Network surgeon and all ancillary providers. The third-party claims administrator will determine the In-Network Bariatric Surgery Center of Excellence facility. It is the participant's responsibility to ensure that all bariatric surgery services providers are In-Network and facilities chosen to provide services are In-Network. Participants can verify the network status of any provider, including a facility, by calling the third-party claims administrator. For more information regarding Bariatric Surgery Centers of Excellence, see the *Key Terms and Definitions*.

Participants are limited to one obesity related surgical procedure of any type in an individual's lifetime while covered under any PEBP-sponsored self-funded plan. For example, a participant cannot have lap band surgery on a PEBP-sponsored self-funded plan and then subsequently seek benefits for gastric bypass on this Plan.

Benefit Description	In-Network	Out-of-Network
Bariatric/Weight Loss Surgery	Plan pays 80% after Plan Year Deductible	Not Covered

Explanation and Limitations
Bariatric/Weight Loss Surgery

If a participant has started any type of program to meet the pre-surgery criteria outlined below with an Out-of-Network provider (including a facility), those services will not meet the Plan's mandatory precertification requirements. For the Plan to consider your bariatric surgery at the In-Network benefit level; you will have to begin the precertification process again with the appropriate In-Network providers.

For lap band adjustments, the Plan will consider any adjustments made in the immediate 12 months following surgery if the participant remains compliant with their post-surgical support group meetings as verified by the UM company. Any adjustments to the lap band after the first 12 months post-surgery will be subject to precertification.

Clinical criteria for weight loss surgeries is managed by the UM Company:

Travel Expenses:
This Plan provides reimbursement of certain costs associated with travel and hotel accommodations for the member and one additional person (spouse/domestic partner, family member or friend) when associated with bariatric/weight loss surgery and performed at a Center of Excellence that is located 50 or more miles from the member's residence. For travel expense benefits, refer to the *Travel Expenses* benefit section.

Expenses incurred for travel and hotel accommodations for bariatric/weight loss surgery not performed at a Center of Excellence are not covered.

Benefit Description	In-Network	Out-of-Network
Behavioral Health Services Mental Health and Substance Abuse	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible

Explanations and Limitations
Behavioral Health Services

Precertification is required for inpatient admissions, including residential treatment facilities, outpatient partial hospitalization programs, and partial residential treatment programs.

Services and supplies for treatment of alcoholism, chemical dependency or drug addiction are covered. Treatment must have a physician's order, include a treatment, and discharge plan. All care must be provided by licensed/credentialed providers—such as hospitals or residential treatment programs for

Benefit Description	In-Network	Out-of-Network
Behavioral Health Services Mental Health and Substance Abuse	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible

Explanations and Limitations

Behavioral Health Services

inpatient care, and non-residential treatment programs (including hospital centers, treatment facilities, physicians and qualified employees of the centers or facilities) for outpatient care.

Behavioral health services payable by this Plan include:

- Outpatient visits
- Acute inpatient admission
- Partial day treatment
- Partial hospitalization
- Intensive outpatient program
- Day treatment
- Psychological testing
- Detoxification

The following behavioral health practitioners are payable under the Plan: psychiatrist (MD or DO), psychologist (Ph.D.), Masters' prepared counselors (e.g., MSW), licensed associate in social work, social worker, independent social worker, or clinical social worker, as well as any licensed provider providing covered services and acting within the scope of their license.

The Plan provides benefits for intermediate levels of care for behavioral health disorders and/or chemical dependency disorders in parity with medical or surgical care of the same level. If the Plan provides benefits for a skilled nursing facility for medical or surgical treatment, the Plan will provide equal behavioral health disorder and/or chemical dependency disorder benefits for intensive outpatient therapy, partial hospitalization, residential treatment, inpatient treatment.

The provider must be licensed or approved by the state in which the services are provided. All care must be provided by licensed, eligible providers—such as hospitals or residential treatment programs for inpatient care and non-residential treatment programs (including hospital centers, treatment facilities, physicians and qualified employees of the centers or facilities) for outpatient care. Precertification is required for inpatient and outpatient care in a facility.

Outpatient prescription drugs for behavioral health payable under the prescription drug benefits.

For information regarding precertification requirements, benefits, and exclusions, refer to the *Utilization Management*, *Key Terms and Definitions*, and *Exclusions* sections.

Benefit Description	In-Network	Out-of-Network
Blood Services for Surgery	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible
Explanations and Limitations Blood Transfusions • Blood transfusions, blood products and equipment for its administration. • Services are covered only when ordered by a physician. • Expenses related to autologous blood donation (patient's own blood) are covered.		

Benefit Description	In-Network	Out-of-Network
Chemotherapy	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge or 110% of the Medi Span AWP, after Plan Year Deductible
Explanations and Limitations Chemotherapy ○ Chemotherapy drugs and supplies administered under the direction of a physician in a hospital, health care facility, physician's office or at home. Covered when ordered by a physician; chemotherapy must be pre-certified by the UM company. ○ See prescription benefits for orally administered chemotherapy drugs: ○ Patients undergoing chemotherapy may be eligible for 1 wig, any type, synthetic or not, per Plan Year (excluding sales tax).		
Chiropractic Services Office visit and spinal manipulation services	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible
Explanations and Limitations Chiropractic Services • Services are covered if performed by a licensed provider acting within the scope of their license. • Limited to a maximum of 20 visits per Plan Year. • Maintenance services are not a covered benefit. X-rays performed in conjunction with chiropractic services are payable under the Radiology Services section of this *Schedule of Medical Benefits*.		

Benefit Description	In-Network	Out-of-Network
Clinical Trials	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible
Explanations and Limitations Clinical Trials • The routine medical treatment costs, including all items and services that are otherwise generally available to Plan participants, received as part of a clinical trial or study, may be covered under NRS695G.173. A clinical trial is the process for testing of new types of medical care that are in the final stages of research to find better ways to prevent, diagnose or treat diseases. • Precertification must be obtained from the UM company.		

Benefit Description	In-Network	Out-of-Network
Corrective Appliances		
Prosthetic & Orthotic Devices, other than dental	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible
***Hearing Aids**	Plan pays 80% after Plan Year Deductible (maximum benefit $1,500 per device, per each ear)	Plan pays 50% after Plan Year Deductible (maximum benefit $1,500 per device, per each ear)
Explanations and Limitations Corrective Appliances and Hearing Aids • Coverage is provided for certain corrective appliances that are medically necessary and FDA approved. This Plan pays for the purchase of standard models at the option of the Plan. Repair, adjustment, or servicing of the device or, replacement of the device due to a change in the covered person's physical condition that makes the original device no longer functional or if the device cannot be satisfactorily repaired. • Prosthetics such as limbs and ocular; orthotics such as casts, splints and other orthotic devices used in the reduction of fractures and dislocations; colostomy or ostomy (Orthotic) supplies, hearing aid* (with limitations). • Plan allows up to $120 for one set of lenses (contacts or frame-type) for the treatment of glaucoma or when required following cataract surgery. Soft lenses or sclera shells intended as corneal bandages for patients without the lens of the eye (aphakic). Corrective appliances are covered only when ordered by a physician or health care practitioner. Orthopedic shoes and foot orthotics are not a covered benefit unless the shoe or foot orthotic is permanently attached to a brace.		

Benefit Description	In-Network	Out-of-Network
Corrective Appliances		
Prosthetic & Orthotic Devices, other than dental	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible
***Hearing Aids**	Plan pays 80% after Plan Year Deductible (maximum benefit $1,500 per device, per each ear)	Plan pays 50% after Plan Year Deductible (maximum benefit $1,500 per device, per each ear)

Explanations and Limitations

Corrective Appliances and Hearing Aids

***Hearing aids:** Air conduction hearing aids are considered medically necessary when one or more of the following hearing loss criteria are met in either or both ears:

- Hearing thresholds 40 dB HL or greater at two or more of these frequencies: 500, 1000, 2000, 3000, 4000 Hz; or
- Hearing thresholds 26 dB HL or greater at three of these frequencies; or
- For high frequency hearing loss, defined as loss occurring only above 2000 Hz: a. Hearing thresholds of 26 dB HL or greater at three or more of these frequencies: 2000, 3000, 4000, 6000 or 8000 Hz
- Speech recognition less than 80 percent in either or both ears regardless of hearing threshold level.

Participants who meet the above hearing loss criteria: Each air conduction hearing aid is subject to Deductible, then the Plan pays 80% up to a maximum benefit of $1,500 per device, per device, per each ear, every three years.

Participants may submit a copy of their hearing aid payment receipt from the hearing aid provider to the third-party claims administrator to request reimbursement for the hearing aid benefit, less applicable copayment(s), and to receive credit towards the Out-of-Pocket Maximum.

To help determine what prosthetic or orthotic appliances are covered, see the definitions of "Prosthetics" and "Orthotics" in the *Key Terms and Definitions* section.

Over the Counter hearing aids are excluded from plan benefits.

<table>
<tr><th>Benefit Description</th><th colspan="2">In-Network</th><th>Out-of-Network</th></tr>
<tr><td colspan="4">Diabetes Care Management Disease Program (DCM) (Enhanced Benefits) *</td></tr>
<tr><td>Office Visits</td><td colspan="2">Two office visits covered at 100% per Plan Year, not subject to Deductible</td><td>Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible</td></tr>
<tr><td>Laboratory Test
(must be performed using a free-standing non-hospital-based laboratory)</td><td colspan="2">Two routine lab tests covered at 100% per Plan Year, not subject to Deductible</td><td>Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible</td></tr>
<tr><td></td><td>Preferred Retail Network
Retail 30-Day Supply</td><td>Smart90 Retail or ESI Home Delivery
90-Day Supply</td><td></td></tr>
<tr><td>Preferred Generic</td><td>$5 Copay</td><td>$15 Copay</td><td>Not covered</td></tr>
<tr><td>Preferred Brand</td><td>$25 Copay</td><td>$75 Copay</td><td>Not covered</td></tr>
<tr><td>Non-Preferred Brand</td><td colspan="2">100% copay</td><td>Not covered</td></tr>
<tr><td>Diabetic Supplies
(test strips, insulin syringes, alcohol pads, and lancets)</td><td colspan="2">ESI Home Delivery Pharmacy:
90-Day Supply
$50 Copay per supply item or the lessor of actual cost</td><td>Not covered</td></tr>
<tr><td>Blood Glucose Monitor</td><td colspan="2">ESI Home Delivery: $0 Copay
(limited to one per Plan Year)</td><td>Not covered</td></tr>
<tr><td colspan="4">Explanations and Limitations
Diabetes Care Management Disease program (enhanced benefits)

The Diabetes Care Management (DCM) program is a voluntary opt-in disease management program that provides enhanced benefits to participants diagnosed with diabetes, and who are enrolled in and actively engaged in the program. Benefits provided under the DCM program are not subject to deductible if determined to be preventive under the ACA and IRS guidelines. To enroll:

• Obtain the DCM form by logging into the E-PEBP Portal at www.pebp.state.nv.us, or contact the third-party claims administrator to request the DCM enrollment form. Complete the required information and have your physician sign the form. Send the form to the third-party claims' administrator for processing.
• The effective date of the DCM program will begin on the first day of the month following the third-party claims administrator's receipt and processing of the DCM enrollment request.</td></tr>
</table>

Benefit Description	In-Network	Out-of-Network

Diabetes Care Management Disease Program (DCM) (Enhanced Benefits) *

- Annually, to continue receiving the DCM enhanced benefits for the next plan year, a new DCM form must be completed, signed by both you and your physician, and submitted to the third-party claims' administrator for processing.

Enrolled DCM participants must comply with all the following requirements to receive the enhanced benefits:

- Complete two office visits each Plan Year for a primary diagnosis of diabetes with your primary care physician or endocrinologist.
- Comply with the diabetes medications as prescribed by your physician.
- Complete the appropriate laboratory testing as ordered by your physician.
- Must remain compliant with your physician's prescribed treatment plan in the Diabetes Care Management program.

Enhanced In-Network benefits in the DCM Program include:

- Two physician office visits per Plan Year are paid at the 100% benefit level when billed with a primary diagnosis of diabetes (additional office visits are subject to deductible and coinsurance).
- Two routine laboratory hemoglobin (A1c) blood tests are paid at the 100% benefit level per Plan Year (additional lab services are subject to deductible and coinsurance).
- Diabetes-related medications, such as insulin and Metformin, are eligible for copayments listed in the DCM Pharmacy Benefits and not be subject to the Plan Year Deductible.
- One glucose monitor, per Plan Year at $0 copayment available through the Pharmacy Benefit Manager.
- Diabetic supplies including test strips, lancets, insulin syringes and alcohol pads are eligible for purchase for the lessor of a $50 copay per 90-day supply item, or the cost of the item, when coordinated through the Pharmacy Benefit Manager's Home Delivery program.
- Copayments for Tier 1 (Generic) and Tier 2 (Preferred Brand) drugs apply to the Plan Year Deductible and Out-of-Pocket Maximum.
- Copayments made while enrolled in the DCM program apply to the Plan Year Deductible and Out of Pocket Maximum.

Laboratory services must be performed at an independent (non-hospital-based laboratory) to be covered by this Plan. Refer to the Laboratories services in the Schedule of Medical Benefits.

Other limitations:

- Diabetes Medications: Preferred Retail Network Pharmacies, Smart90 Retail, and Express Scripts Home Delivery Program requirements apply. Refer to the *Schedule of Prescription Drug Benefits* for coverage limitations, cost implications and details regarding these programs.
- Participants who are not enrolled or non-compliant in the DCM Program receive the standard CDHP benefits. The effective date of the return to the standard CDHP benefits will be the first day of the month following the non-compliance determination by the third-party claims administrator.

Benefit Description	In-Network	Out-of-Network
Diabetes Care Management Disease Program (DCM) (Enhanced Benefits) *		
• Specialty medications are not eligible for enhanced benefits under this program and are subject to the standard CDHP benefits. • This Plan does not coordinate prescription drug benefits. • Medications purchased at Out-of-Network pharmacies are not covered under this Plan.		
Diabetes Education Services	This Plan pays 80% after Plan Year Deductible	Not Covered
Explanations and Limitations Diabetes Education Services • Diabetes training and education services are payable when requested by a physician and are medically necessary for the self-care and self-management of a person with diabetes. Services must be provided by a certified diabetes educator or a health care practitioner. Included in this benefit is retraining due to new techniques for the treatment of diabetes or when there has been a significant change in the person's clinical condition or symptoms that requires modification of self-management techniques. • Some diabetic supplies are payable under the *Prescription Drug* section of this document. Please contact the prescription drug Plan Administrator for more information. • This Plan pays enhanced benefits for participants enrolled in and actively engaged in the Diabetes Care Management (DCM). For information regarding the DCM program and the enhanced benefits, refer to the Disease Management section and to the *Schedule of Medical Benefits* for the Diabetes Care Management Program.		

Benefit Description	In-Network	Out-of-Network
Dialysis	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible

Explanations and Limitations
Dialysis

- Hemodialysis or peritoneal dialysis and supplies.
- Covered when ordered by a physician and administered in a hospital, health care facility, and physician's office or at home. Outpatient, inpatient or home dialysis must be prior authorized by PEBP's utilization management company.
- See the *Utilization Management* information.

Benefit Description	In-Network	Out-of-Network
Durable Medical Equipment (DME)	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible

Explanations and Limitations
Durable Medical Equipment (DME)

- DME requires precertification by the UM company when the cost is expected to exceed $1,000.
- Rental of DME to cover Medicare guidelines concerning rental to purchase criteria.
- Repair or maintenance of standard models at the option of the Plan to include equipment maintenance agreements.
  - Repair, adjustment or servicing or medically necessary replacement of the DME due to a change in the covered person's physical condition, or if the equipment cannot be satisfactorily repaired.
- DME, including oxygen, equipment, and supplies required for its administration, is covered only when its use is medically necessary, and it is ordered by a physician or health care practitioner.
- Certain blood glucose monitors are covered under this Plan. In-Network, the Plan pays 80% after the Plan Year Deductible.
- Participants enrolled in and actively engaged in the Diabetes Care Management Program are eligible to receive one glucose monitor each Plan Year at no cost in accordance with the DCM Program requirements, refer to the *Diabetes Care Management Disease Program (DCM) (Enhanced Benefits) ** pumps are eligible for purchase and must be prior authorized by the UM company.

- Rental to purchase following Medicare guidelines for certain lifelong DME. Examples of lifelong durable medical equipment include CPAP and BiPAP machines, and electric wheelchairs for paralysis. Please check with PEBP's third-party claims administrator or utilization management company for assistance. Contact the third-party claims administrator for the purchase of certain DME such as breast pumps.

See the *Exclusions* section related to corrective appliances and durable medical equipment. To help determine what durable medical equipment is covered, see the definition of "Durable Medical Equipment" in *Key Terms and Definitions*.

Benefit Description	In-Network	Out-of-Network
No Surprises Act		
Emergency Room	Plan pays 80% after Plan Year Deductible	Plan pays 80% of the Maximum Allowable Charge after Plan Year Deductible, subject to the No Surprises Act.
Urgent Care Services	Plan pays 80% after Plan Year Deductible	Plan pays 80% of the Maximum Allowable Charge after Plan Year Deductible

Explanations and Limitations

Emergent and Urgent Care Services

The federal No Surprises Act protects patients who receive emergency services at a hospital, at an independent freestanding emergency department and from air ambulances. In addition, the law protects patients who receive emergency services from a Non-PPO provider at an in-network facility. Beneficiaries receiving these services will only be responsible for paying their in-network cost sharing, and cannot be balance billed by the provider or facility for emergency services.

Emergency Services

Emergency Services are covered:

- Without the need for a prior authorization determination, even if the services are provided out-of-network;
- Without regard to whether the health care provider furnishing the Emergency Services is a PPO provider or a PPO emergency facility, as applicable, with respect to the services;
- Without imposing any administrative requirement or limitation on out-of-network Emergency Services that is more restrictive than the requirements or limitations that apply to Emergency Services received from PPO providers and PPO emergency facilities;
- Without imposing cost-sharing requirements on out-of-network Emergency Services that are greater than the requirements that would apply if the services were provided by a PPO provider or a PPO emergency facility;

- By calculating the cost-sharing requirement for out-of-network Emergency Services as if the total amount that would have been charged for the services were equal to the Recognized Amount for the services; and
- By counting any cost-sharing payments made by the participant or beneficiary with respect to the Emergency Services toward any in-network deductible or in-network out-of-pocket maximums applied under the plan (and the in-network deductible and in-network out-of-pocket maximums are applied) in the same manner as if the cost-sharing payments were made with respect to Emergency Services furnished by a PPO provider or a PPO emergency facility.

Your cost sharing amount for Emergency Services from Non-PPO Providers will be based on the lessor of billed charges from the provider or the Qualified Payment Amount (QPA).

*see also **NRS** 695G.170 for medically necessary emergency services at any hospital in Nevada.

Post Stabilization Services

Emergency Services furnished by a Non-PPO Provider or Non-PPO emergency facility (regardless of the department of the hospital in which such items or services are furnished also includes post stabilization services (services after the patient is stabilized) and as part of outpatient observation or an inpatient or outpatient stay related to the emergency medical condition, until:

- The provider or facility determines that the participant or beneficiary is able to travel using nonmedical transportation or nonemergency medical transportation; and
- The participant or beneficiary is supplied with a written notice, as required by federal law, that the provider is a Non-PPO provider with respect to the Plan, of the estimated charges for your treatment and any advance limitations that the Plan may put on your treatment, of the names of any PPO providers at the facility who are able to treat you, and that you may elect to be referred to one of the participating providers listed; and
- The participant or beneficiary gives informed consent to continued treatment by the nonparticipating provider, acknowledging that the participant or beneficiary understands that continued treatment by the nonparticipating provider may result in greater cost to the participant or beneficiary.

Non-Emergency Items or Services from a Non-PPO Provider at a PPO Facility

With regard to non-emergency items or services that are otherwise covered by the Plan, if the covered non-emergency items or services are performed by a Non-PPO provider at a PPO facility, the items or services are covered by the plan:

- With a cost-sharing requirement that is no greater than the cost-sharing requirement that would apply if the items or services had been furnished by a PPO provider,
- By calculating the cost-sharing requirements as if the total amount that would have been charged for the items and services by such Non-PPO provider were equal to the Recognized Amount for the items and services.
- By counting any cost-sharing payments made by the participant or beneficiary toward any in-network deductible and in-network out-of-pocket maximums applied under the plan (and the in-

network deductible and out-of-pocket maximums must be applied) in the same manner as if such cost-sharing payments were made with respect to items and services furnished by a PPO provider,

- Non-emergency items or services performed by a Non-PPO provider at a PPO facility will be covered based your out-of-network coverage if:
  - At least 72 hours before the day of the appointment (or three (3) hours in advance of services rendered in the case of a same-day appointment), the participant or dependent is supplied with a written notice, as required by federal law, that the provider is a Non-PPO provider with respect to the Plan, of the estimated charges for your treatment and any advance limitations that the Plan may put on your treatment, of the names of any PPO providers at the facility who are able to treat you, and that you may elect to be referred to one of the PPO providers listed; and
  - The participant or dependent gives informed consent to continued treatment by the Non-PPO provider, acknowledging that the participant or beneficiary understands that continued treatment by the Non-PPO provider may result in greater cost to the participant or beneficiary.
- The notice and consent exception does not apply to Ancillary services and items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished, regardless of whether the Non-PPO provider satisfied the notice and consent criteria, and therefore these services will be covered:
  - With a cost-sharing requirement that is no greater than the cost-sharing requirement that would apply if the items or services had been furnished by a PPO provider,
  - With cost-sharing requirements calculated as if the total amount charged for the items and services were equal to the Recognized Amount for the items and services, and
- With cost-sharing counted toward any in-network deductible and in-network out of pocket maximums, as if such cost-sharing payments were with respect to items and services furnished by a PPO provider.

Your cost sharing amount for Non-emergency Services at PPO Facilities by Non-PPO Providers will based on the lessor of billed charges from the provider or the Qualifying Payment Amount.

Air Ambulance Services

If you receive Air Ambulance services that are otherwise covered by the Plan from a non-PPO provider, those services will be covered by the Plan as follows:

- The Air Ambulance services received from a Non-PPO provider will be covered with a cost-sharing requirement that is no greater than the cost-sharing requirement that would apply if the services had been furnished by a PPO provider.
- In general, you cannot be balance billed for these items or services. Your cost-sharing will be calculated as if the total amount that would have been charged for the services by a PPO provider of Air Ambulance services were equal to the lesser of the Qualifying Payment Amount or the billed amount for the services.

- Any cost-sharing payments you make with respect to covered Air Ambulance services will count toward your Network (PPO) deductible and Network (PPO) out-of-pocket maximum in the same manner as those received from a PPO provider.

Payments to non-PPO Providers and Facilities

The Plan will make an initial payment or notice of denial of payment for Emergency Services. Non-Emergency Services at PPO Facilities by Non-PPO Providers, and Air Ambulance Services within 30 calendar days of receiving a clean claim from the Non-PPO provider. The 30-day calendar period begins on the date the plan receives the information necessary to decide a claim for payment for the services.

If a claim is subject to the No Surprises Act, the participant cannot be required to pay more than the cost-sharing under the Plan, and the provider or facility is prohibited from billing the participant or dependent in excess of the required cost-sharing.

The Plan will pay a total plan payment directly to the non-PPO provider that is equal to the amount by which the Out-of-Network Rate for the services exceeds the cost-sharing amount for the services, less any initial payment amount.

External Review

An Adverse Benefit Determination that is related to an Emergency Service, Non-Emergency Service provided by a non-PPO provider at a PPO facility, and/or Air Ambulances services, as covered under the federal No Surprises Act, is eligible for External Review. Please see the External Review procedures in the SPD for further information.

Continuity of Coverage

If you are a Continuing Care Patient, and the contract with your Network provider or facility terminates, or your benefits under a group health plan are terminated because of a change in terms of the providers' and/or facilities' participation in the plan:

1. You will be notified in a timely manner of the contract termination and of your and of your right to elect continued transitional care from the provider or facility; and
2. You will be allowed up to ninety (90) days of continued coverage at Network cost sharing to allow for a transition of care to a Network provider.

Incorrect PPO Provider Information

A list of PPO providers is available to you without charge by visiting the website or by calling the phone number on your ID card. The network consists of providers, including hospitals, of varied specialties as well as general practice, who are contracted with the Plan or an organization contracting on its behalf.

If you obtain and rely upon incorrect information about whether a provider is a PPO provider from the Plan or its administrators, the Plan will apply PPO cost-sharing to your claim, even if the provider was Non-PPO.

-

Benefit Description	In-Network	Out-of-Network
Family Planning, Fertility, Infertility, Sexual Dysfunction Services and Male Contraception	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible

Explanations and Limitations
Family Planning, Fertility, Infertility, Sexual Dysfunction Services and Male Contraception

- Only diagnostic procedures for fertility and infertility are payable for the employee and spouse/domestic partner.
- No coverage for the treatment of fertility or infertility. See the *Exclusions* section *for* drugs, medicines, and nutrition; fertility and infertility; maternity services; and sexual dysfunction services.
- Diagnostic procedures for fertility and infertility are subject to the Plan Year Deductible.
- .
- Procedures related to sexual dysfunction may be covered. See the *Exclusions* section of this document for more information.
- Coverage is provided for vasectomies and tubal ligations. Reversals of prior sterilization procedures, including, but not limited to tubal ligation and vasectomy reversals are excluded.
- Male surgical sterilization is subject to the Plan Year Deductible and Coinsurance.
- Male contraception such as condoms are not covered under this Plan.

Benefit Description	In-Network	Out-of-Network
Gender Dysphoria Related Services	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible

Explanations and Limitations

Treatment of Gender Dysphoria

This Plan provides benefits to individuals seeking services for the treatment of gender dysphoria.

All procedures, services, and supplies related to surgery and sex hormones associated with gender affirmation/confirmation should be reviewed by the UM company for medical necessity.

The Plan limits a member to one surgery-type in an individual's lifetime while covered under any current or previous PEBP self-funded plan.

Reversals of surgery will not be covered.

Benefit Description	In-Network	Out-of-Network
Genetic Counseling/Testing	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible

Explanations and Limitations

Genetic Testing and Counseling

Certain Genetic Testing and Counseling require precertification. Contact the UM company for precertification requirements for covered genetic testing.

Benefits include amniocentesis, non-invasive pre-natal testing for fetal aneuploidy, chorionic villus sampling (CVS), alpha-fetoprotein (AFP), BRCA1 and BRCA2, apo E.

- Amniocentesis, non-invasive pre-natal testing for fetal aneuploidy, chorionic villus sampling (CVS), and alpha-fetoprotein (AFP) analysis in pregnant women only if the procedure is medically necessary as determined by the UM company.
- Genetic counseling when provided before and/or after amniocentesis, non-invasive pre-natal testing for fetal aneuploidy, chorionic villus sampling (CVS), and alpha-fetoprotein (AFP) analysis.
- BRCA1 and BRCA2 counseling for individuals already diagnosed with breast and/or ovarian cancer.
- Apo E genetic test to help physicians identify those individuals at highest risk for heart disease and determine the most appropriate dietary and fitness program for the covered PEBP participant.
- BRCA1 and BRCA2 genetic test
  - BRCA1 and BRCA 2 testing may be covered under the Preventive/Wellness benefit when indicated after genetic counseling in accordance with the USPSTF A & B recommendation.

This list is not all inclusive for what genetic tests may be covered. Contact the UM company for coverage details and precertification requirements for covered genetic testing.

See the *Key Terms and Definitions* and the *Exclusions* sections relating to genetic testing and counseling, including non-payment for pre-parental genetic testing.

Benefit Description	In-Network	Out-of-Network
Hearing Aids		
Explanations and Limitations Hearing Aids See *Corrective Appliances*, above.		

Benefit Description	In-Network	Out-of-Network
Home Health Care and Home Infusion Services	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible; or for infusion drug services 110% of the Medi-Span AWP after Plan Year Deductible

Explanations and Limitations

Home Health Care and Home Infusion Services

- Home Health Care and Home Infusion requires precertification by the UM company.
- Home health care and home infusion services are covered only when ordered by a physician or health care practitioner.
- Benefits include part-time, intermittent skilled nursing care services and medically necessary supplies to provide home health care or home infusion services, subject to maximum Plan benefits.
- The maximum Plan benefit for home health care (skilled nursing care services) and supplies to provide home health care and home infusion services is 60 visits per person per Plan Year. Additional visits are subject to preauthorization by the UM Company.
- A home health care visit will be considered a periodic visit by a nurse or therapist, or four (4) hours of home health services.
- Charges are covered for private duty nursing by a licensed nurse (RN or LVN/LPN) only when care is medically necessary and not custodial in nature. Outpatient private duty nursing care on a 24-hour shift basis is not covered.
- Outpatient private duty nursing care on a 24-hour shift basis and/or home services other than skilled nursing care are not covered.
- Home services other than skilled nursing care are not covered
- See *Exclusions* section related to home health care and custodial care, including personal care and childcare.

Benefit Description	In-Network	Out-of-Network
Hospice	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible

Explanations and Limitations

Hospice

The hospice care program administers palliative and supportive health care services providing physical, psychological, social, and spiritual care for terminally ill patients.

- The following hospice care services are covered for members with a terminally ill, limited life expectancy of six (6) months. Additional days would have to be preauthorized by the UM Company: Part-time intermittent home health care services totaling fewer than 8 hours per day and 35 or fewer hours per week
- Outpatient bereavement counseling services provided by a licensed masters level clinician or a licensed pastoral care counselor for the patient's immediate family (covered spouse and or dependent children) as provided as part of the hospice service. Bereavement counseling beyond that included as a part of the hospice program is payable under the Behavioral Health benefits of this Plan.

For more information, see Hospice Care in the *Key Terms and Definitions* section.
See Hospice Care in the *Key Terms and Definitions* section for additional information.

Benefit Description	In-Network	Out-of-Network
Hospital Services (Inpatient)	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible

Explanations and Limitations

Hospital Services (Inpatient)

Elective hospitalization is subject to precertification. All hospitalization is subject to concurrent review. See the *Utilization Management* section for more information.

- Room and board and facility fees in a semiprivate room with general nursing services; Specialty Care Units (e.g., intensive care unit, cardiac care unit); lab, x-ray, and diagnostic services; related medically necessary ancillary services (e.g., prescriptions, supplies).
- Newborn care and circumcision.
- Elective hospitalization is subject to precertification. All hospitalization is subject to concurrent review. See the *Utilization Management* section for more information.
- Private room is payable at the semi-private rate unless it is determined that a private room is medically necessary, or the facility does not provide semi-private rooms.
- Outpatient services with an observation period that lasts more than 23 hours will be considered and paid as an inpatient confinement under this Plan.
- Under the following circumstances, the medical Plan will pay for the facility fees and anesthesia associated with medically necessary dental services if the utilization review company determines

Benefit Description	In-Network	Out-of-Network
Hospital Services (Inpatient)	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible

Explanations and Limitations
Hospital Services (Inpatient)
that hospitalization is medically necessary to safeguard the health of the patient during performance of dental services:
• Under the following circumstances, the medical Plan will pay for the facility fees and anesthesia associated with medically necessary dental services if the utilization review company determines that hospitalization is medically necessary to safeguard the health of the patient during performance of dental services.
  • Dental general anesthesia for an individual when services are rendered in a hospital or outpatient surgical facility, when the individual is being referred because in the opinion of the dentist, the individual:
  • Is under age 18 and has a physical, mental, or medically compromising condition; or
  • Is under age 18 and has dental needs for which local anesthesia is ineffective because of an acute infection, an anatomic anomaly, or an allergy; or
  • Patient has a documented mental or physical impairment requiring general anesthesia for the safety of the patient.
  • Is under age seven (7) and diagnosed with extensive dental decay substantiated by x-rays and narrative reporting provided by the dentist.
  • No payment is extended toward the dentist or the assistant dental provider under this Plan.
• No coverage for non-emergency hospital admission: No coverage for care and treatment billed by a hospital for a non-medical emergency admission on a Friday or Saturday unless surgery is performed within 24 hours of the admission.
• Inpatient private duty nursing by a licensed nurse (RN, LVN or LPN) is covered only when care is medically necessary and not custodial, and the hospital's intensive care unit is filled, or the hospital has no intensive care unit.		

Benefit Description	In-Network	Out-of-Network
Laboratory Outpatient Services		
Free-standing lab facility Preferred non-hospital-based lab facilities: Lab Corp or Quest	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible
Outpatient hospital-based lab facility and hospital-based lab draw station Lab services for pre-admission testing, urgent care, and emergency room only	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible

Benefit Description	In-Network	Out-of-Network
Laboratory Outpatient Services		

Explanations and Limitations

Laboratory Outpatient Services

- Outpatient lab services are covered when medically necessary, when ordered by a physician or health care practitioner, and when services are performed in accordance with the Laboratory Outpatient Services benefit described in this section.

Free-standing, non-hospital -based laboratory facility: The Plan covers outpatient routine and preventive lab services performed at free-standing, non-hospital-based lab facilities. Although there may be other in-network free-standing, non-hospital-based lab facilities in the network, the Plan's preferred facilities include Lab Corp and Quest. Routine and preventive lab services include:

  - Medically necessary routine labs when ordered by a physician or other licensed provider acting within the scope of his/her license as part of comprehensive medical care.
  - Preventive laboratory services such as but not limited to basic metabolic panel, lipid, or general health panel. Refer to the *Preventive Care/Wellness Services* for information regarding benefits for screening tests and preventive lab testing.

- **Outpatient hospital-based lab facilities and hospital-based lab draw stations:** The Plan covers outpatient lab services for pre-admission testing when performed 7 days prior to a scheduled hospital admission or outpatient surgery. The testing must be related to the sickness or injury for which admission or surgery is planned.
- If a free-standing, non-hospital-based outpatient laboratory facility not available within 50 miles of your residence, you may use a hospital-based laboratory facility or hospital-based draw station.
- See the *Key Terms and Definitions* section for the definitions of *Free-standing Laboratory Facility* and *Outpatient Hospital-Based* Laboratory and *Outpatient Hospital-Based Laboratory Draw Station.*

Benefit Description	In-Network	Out-of-Network
Maternity and Newborn Services	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible

Explanations and Limitations

Maternity Services

- This Plan covers hospital and birth (birthing) center charges and professional fees for medically necessary maternity services.
- Prenatal and delivery is covered for an employee or spouse/domestic partner only. For covered dependent children, only prenatal coverage is provided for maternity, except for complications of pregnancy for the dependent child (see the definition of Complications of Pregnancy in the *Key Terms and Definitions* section of this document).
- Some preventive prenatal services including, but not limited to, obstetrical office visits, breastfeeding support, screening for gestational diabetes, blood type and Rh lab services for spouses

and dependent children may be covered under the preventive care benefit. The preventive benefit does not include delivery of the newborn(s).

- Coverage for newly born and adopted children and children placed for adoption includes coverage of injury or sickness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities and, within the limits of the policy, necessary transportation costs from place of birth to the nearest specialized treatment center under major medical policies, and with respect to basic policies to the extent such costs are charged by the treatment center.
- Hospital length of stay for childbirth: This Plan complies with federal law that prohibits restricting benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, or requiring a health care practitioner to obtain authorization from the Plan or its UM Company for prescribing a length of stay not more than those periods. However, federal law generally does not prohibit the mother's or newborn's attending health care practitioner, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, if applicable).
- Elective termination of pregnancy is covered only when the attending physician certifies that the mother's health would be endangered if the fetus were carried to term. Termination of pregnancy - See the Genetic Testing section of this *Schedule of Medical Benefits*.
- See Breastfeeding Support section for information and benefits related to this type of service. See the exclusions related to Maternity Services in the *Exclusions* section.
- See the *Enrollment and Eligibility Master Plan Document* for information regarding how to enroll a newborn dependent child(ren).
- When the member has Employee-Only coverage, the newborn will be covered under the member's plan for the first 31 days (NRS 689B.033). Individual deductible, copay, coinsurance, and out of pocket limitations, where applicable, will apply during the initial coverage period.

Benefit Description	In-Network	Out-of-Network
Nondurable Supplies	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge or 110% of the Medi-Span AWP after Plan Year Deductible

Explanations and Limitations

Nondurable Supplies

Coverage is provided for up to a 31-day supply per month of:

- Sterile surgical supplies used immediately after surgery.
- Supplies needed to operate, or use covered durable medical equipment or corrective appliances.
- Supplies needed for use by skilled home health or home infusion personnel, but only during their required services.

To determine what nondurable medical supplies are covered, see the definition of Nondurable Supplies in the *Key Terms Definitions* section.

Please see the *Participant Contact Guide* for information regarding the preferred diabetic supplies mail order program.

Diabetic supplies are also payable under the prescription drug benefit, see the section on *prescription drug benefits* in this document for more information.

Benefit Description	In-Network		Out-of-Network
Obesity Care Disease Management Program (Enhanced Benefits)			
Office Visits	Plan pays 100%; not subject to Deductible		Plan pays 50% of the Maximum Allowable Charge after Deductible
Laboratory Test (must be performed using a free-standing, non-hospital-based laboratory)	Plan pays 100%; not subject to Deductible		Plan pays 50% of the Maximum Allowable Charge after Deductible
Nutritional Counseling Services	Plan pays 100%; not subject to Deductible		Plan pays 50% of the Maximum Allowable Charge after Deductible
Weight loss medications	Preferred Retail 30-Day Supply	Smart90 Retail or ESI Home Delivery 90-Day Supply	
Preferred Generic	*$5 Copay	$15 Copay	Not covered
Preferred Brand	*$25 Copay,	*$75 Copay,	Not covered
Non-Preferred Brand	Not covered		Not covered

Explanations and Limitations

Obesity Care Disease Management Program (Enhanced Benefits)

Preferred Retail Network Pharmacies: Copayments apply if you fill your prescription at a EAN retail pharmacy. If you fill your prescription at a non-EAN retail pharmacy, you will pay an additional $10 per prescription. If you currently use a non-EAN pharmacy and you want to avoid the $10 upcharge, call an EAN pharmacy to transfer your prescription. Certain weight loss medications may not be available in 90-day supply. Contact Express-Scripts for information about your prescribed medication.

The Obesity Care Management **(**OCM) Program is a disease management program that provides enhanced benefits to participants who have been diagnosed as obese by their physician, who meet the criteria in this section, and have enrolled in the OCM Program.

The OCM Program is a voluntary opt-in program that requires enrollment with the third-party claims administrator to determine if you meet the criteria for participation in the program. If the third-party claims administrator determines you to be eligible for the program, the effective date of enrollment and

Benefit Description	In-Network	Out-of-Network
Obesity Care Disease Management Program (Enhanced Benefits)		

enhanced benefits is determined by the third-party claims administrator. For enrollment information, contact the third-party claims administrator listed in the *Participant Contact Guide*.

How to enroll in the OCM Program:

- Contact the third-party claims administrator for a list of In-Network weight loss providers. The list of In-Network weight loss providers and the *OCM Enrollment and Evaluation Form* may be obtained by logging into the E-PEBP Portal at *www.pebp.state.nv.us* and selecting UMR.
- Schedule an appointment with a provider from the list of participating In-Network weight loss providers.
- Attend your scheduled appointment and have your provider complete, sign and submit the *Enrollment and Evaluation Form* to the third-party claims administrator's address or fax number provided on the form.
- The third-party claims administrator will review the information submitted by your provider and if the information indicates that you meet the criteria for the weight loss program benefits, the third-party claims administrator will enroll you in the program and notify the Pharmacy Benefit Manager of your enrollment.
- If you do not meet the criteria for the weight loss program and enhanced benefits, the third-party claims administrator will notify of the denial of the OCM Program's enhanced benefits.

OCM Program participation criteria for adults 18 years and older and services must be provided by:

- An In-Network provider who specializes in weight loss services.
- An In-Network provider who is certified by the American Board of Bariatric Medicine (ABBM).
- An In-Network provider who is in training to become certified by the American Board of Bariatric Medicine (ABBM); or
- If no provider as described above is available within 50 miles of a participant's residence, any In-Network provider.

The patient's BMI must be greater than 30 kg/m2, with or without any co-morbid conditions present, or greater than 25 kg/m2 (or waist circumference greater than 35 inches in women, 40 inches in men) if one or more of the following co-morbid conditions are present:

- Coronary artery disease.
- Diabetes mellitus type 2.
- Hypertension (Systolic Blood Pressure greater than or equal to 140 mm Hg or Diastolic Blood Pressure greater than or equal to 90 mm Hg on more than one occasion).
- Obesity-hypoventilation syndrome.
- Obstructive sleep apnea.
- Cholesterol and fat levels measured (Dyslipidemia):
  - HDL cholesterol less than 35 mg/dL.
  - LDL cholesterol greater than or equal to 160 mg/dL; or
  - Serum triglyceride levels greater than or equal to 400 mg/dL.

For children ages two to 18 years:

Benefit Description	In-Network	Out-of-Network
Obesity Care Disease Management Program (Enhanced Benefits)		

- All the above criteria.
- Services must be provided by an In-Network provider who specializes in childhood obesity; and
- Child must present a BMI ≥ 85th percentile for age and gender.

Engagement in the OCM Program:
In addition to meeting the criteria above, you must remain actively engaged by complying with the treatment plan established by you and weight loss provider.

Monitoring Engagement in the OCM Program:
Your OCM provider must submit monthly reports to include your weight loss (weight, BMI, and waist circumference) and your compliance with the treatment plan. Submission of these reports will be a requirement for payment under the OCM Program's enhanced benefits. If your monthly weight loss reports are not received by the third-party claim's administrator, your benefits under this program will end, and your coverage will return to the standard CDHP benefits where other Plan limitations will apply. The effective date of the return to the standard CDHP benefits will be the first day of the month following the non-compliance notification received from the third-party claim's administrator.

You and your weight loss provider will determine your final weight loss goal when you initially start participating in the OCM Program. Once you have met your final weight loss goal, the OCM Program's enhanced benefits will return to the standard CDHP benefits on the first day of the following month. The OCM Program does not provide enhanced benefits for ongoing maintenance care. Ongoing maintenance care will be subject to the standard CDHP benefits.

Laboratory Services:
Routine wellness laboratory testing must be performed at an In-Network free-standing laboratory facility, for example Lab Corp or Quest. A hospital-based outpatient laboratory/draw station is not a free-standing laboratory.

Nutritional Counseling Services:
The frequency of nutritional counseling services will be determined by the claims administrator and based on your weight loss provider's recommendation and medical necessity.

Weight Loss Medications:
- The Plan covers certain only short-term use obesity/weight loss generic medications as identified by the Plan's pharmacy benefits manager. Contact the pharmacy benefit manager or refer to the Plan's prescription drug formulary to determine what weight loss medications are covered by the enhanced benefit.
- Copayment for a 31-90-day supply is subject to three times the listed 30-day retail copayment.
- This Plan does not coordinate prescription drug plan benefits.
- Medications purchased at non-participating pharmacies are not covered under this Plan.

Other limitations:

Benefit Description	In-Network	Out-of-Network
Obesity Care Disease Management Program (Enhanced Benefits)		
• Weight loss medications: Preferred Retail Network Pharmacies, Smart90 Retail, and Express Scripts Home Delivery Program requirements apply. Refer to the *Schedule of Prescription Drug Benefits* for coverage limitations, cost implications and details regarding these programs. **The Obesity Care Management Program is administrated by the Claims Administrator.**		

Benefit Description	In-Network	Out-of-Network
Oral Surgery, Dental Services, and Temporomandibular Joint Disorder Injury to teeth; Oral and or craniofacial surgery.	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Deductible
	*TMJ related services: Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Deductible

Explanations and Limitations
Oral and Craniofacial Services

- Expenses for dental services may be covered under the medical plan if the expenses are incurred for the repair or replacement of injury to teeth or restoration of the jaw if damaged by an external object in an accident. For the purposes of this coverage by the medical Plan, an accident does not include any injury caused by biting or chewing.
  - Treatment of injury to teeth must be provided by a dentist or physician and is limited to restoration of teeth to a functional level, as determined by the Plan Administrator or its designee.
- Coverage for dental services as the result of an injury to teeth will be extended under the medical plan to a maximum of two years following the date of injury, regardless of date enrolled in the plan. Restorations past the two-year time frame may be considered under the dental benefits described in the PEBP Self-funded Dental PPO Plan Master Plan Document available at www.pebp.state.nv.us.
- Certain oral or craniofacial surgery is required to be prior authorized by the utilization management company. See the *UM* section of this document or refer to *Participant Contact Guide*.
- Oral or craniofacial surgery is limited to surgical procedures to remove tumors, cysts, abscess including dental abscess and cellulitis, or for acute injury.
- Frenectomy based on medical necessity as determined by the UM company.
- *Temporomandibular Joint (TMJ) services are payable under the medical Plan when medically necessary but not if treatment is recognized as a dental procedure, involves extraction of teeth or application of orthodontic devices (e.g., braces) or splints.

For additional information, see the *Exclusions* section related to dental services.

Benefit Description	In-Network	Out-of-Network
Outpatient Surgery Facility	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Deductible

Explanations and Limitations
Outpatient Surgery Facility

- See the *UM* section for precertification requirements.
- Outpatient ambulatory surgical facility/surgical center.
- Physician fees payable under the physician services section of this *Schedule of Medical Benefits*.
- Outpatient surgery with an observation period that lasts more than 23 hours will be considered and paid as an Inpatient confinement under this medical Plan.
- Outpatient facility fees and anesthesia associated with medical necessary dental services for an individual when the individual is being referred by the dentist, and the following criteria are met:
  - Is under age 18 and has a physical, mental, or medically compromising condition; or
  - Is under age 18 and has dental needs for which local anesthesia is ineffective because of an acute infection, an anatomic anomaly, or an allergy; or patient has a documented mental or physical impairment requiring general anesthesia for the safety of the patient; or is under age seven (7) and diagnosed with extensive dental decay substantiated by x-rays and narrative reporting provided by the dentist.
  - No payment is extended toward the dentist or the assistant dental provider fees under this medical Plan. Refer to the dental benefits described in the PEBP Self-funded PPO Dental Plan Master Plan Document available at *www.pebp.state.nv.us*.

Benefit Description	In-Network	Out-of-Network
Physician and Other Health Care Practitioner Services	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible

Explanations and Limitations
Physician and Other Health Care Practitioner Services

This benefit includes physician and health care practitioner's fees for services provided in a hospital, emergency room, urgent care center, a health care practitioner's office or at home. Physician and health care practitioners include licensed providers acting within the scope of their license, such as but are not limited to the following:

- Surgeon
- Assistant surgeon (if medically necessary)
- Anesthesia by physicians and Certified Registered Nurse Anesthetists (CRNA)
- Pathologist; Radiologist
- Physician Assistant; Nurse Practitioner; Nurse Midwife
- Homeopathic Physicians, Christian Science Practitioners, Oriental Medicine Doctor (OMD) only for Acupuncture
- Podiatrist

Benefit Description	In-Network	Out-of-Network
Physician and Other Health Care Practitioner Services	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible
Explanations and Limitations Physician and Other Health Care Practitioner Services • Psychologist, Psychiatrist, Licensed Clinical Social Worker The Plan Administrator or its designee will determine if multiple surgical or other medical procedures will be covered as separate procedures or as a single procedure based on the factors in the definition of "Surgery/Surgeries" in the *Key Terms and Definitions* section. Assistant surgeon fees will be reimbursed for medically necessary services to a maximum of 20% of the eligible expenses payable to the primary surgeon. A Certified Surgical Assistant (see *Key Terms and Definitions* section) is payable as an assistant surgeon. Podiatry benefits include routine foot care for the treatment of foot problems such as bunions, corns, calluses, and toenails are covered only for individuals with a metabolic disorder such as diabetes, or a neurological or peripheral-vascular insufficiency affecting the feet. No coverage is provided for prophylactic surgery or treatment as defined in the *Key Terms and Definitions* section and as explained in the *Exclusions* section, unless otherwise specified in this document. No coverage for homeopathic treatments, supplies, remedies, or substances.		

Benefit Description	In-Network	Out-of-Network
Preventive Care/Wellness Benefits	Plan pays 100%, not subject to Deductible	Not Covered
Colorectal Cancer Screening (Colonoscopy/bowel prep, or Cologuard)	Plan pays 100%, not subject to Deductible	Not Covered
Women's Preventive Services *Well-woman visits; screening for gestational diabetes; human papillomavirus testing; counseling/screening: human immune deficiency virus, interpersonal and domestic violence*	Plan pays 100%, not subject to Deductible	Not Covered
BRCA Risk Assessment and Genetic Counseling/Testing	Plan pays 100%; not subject to Deductible	Not Covered
BRCA Risk Assessment and Genetic Counseling/Testing in accordance with the USPSTF A & B guidelines; BRCA testing requires Precertification.		
Breastfeeding Support/Equipment*	Plan pays 100%, Not subject to Deductible	Plan pays 50% of the Maximum Allowable Charge after

Benefit Description	In-Network	Out-of-Network
Preventive Care/Wellness Benefits	Plan pays 100%, not subject to Deductible	Not Covered
		Deductible

*Coverage for comprehensive lactation support and counseling from trained providers for women during the prenatal and postpartum period and up to one year following delivery. Coverage for breastfeeding equipment and supplies in conjunction with each live birth. The Plan covers one manual or standard electric breast pump per live birth. *Contact the third-party claims administrator for the purchase of covered breast pumps. Rental for heavy duty electrical (hospital grade) breast pump covered only when the UM company determines it is medically necessary and only during the newborn's inpatient hospital stay.*

Contraceptives / Family Planning (females only)	Plan pays 100%, not subject to Deductible	Plan pays 50% of the Maximum Allowable Charge after Deductible; pharmacy not covered

Contraceptives/Family Planning: This Plan complies with NRS 695G.1715; required provision concerning coverage for up to a 12-month supply of FDA approved contraceptive methods, including sterilization procedures, and patient education and counseling for all women with reproductive capacity. The FDA requires the services, including over-the-counter products/methods to be prescribed by a physician.

• *Elective sterilization* • *Surgical sterilization implant* • *Implantable rods* • *Copper-based intrauterine devices* • *Progesterone-based intrauterine devices* • *Injections*	• *Progestin-based drugs* • *Extended/continuous -regimen drugs* • *Estrogen and progestin-based patches* • *Vaginal contraceptive rings* • *Combined estrogen- and progestin-based drugs*	• *Diaphragms w/spermicide* • *Sponges w/spermicide* • *Cervical caps w/spermicide* • *female condoms* • *Spermicide*	• *Combined estrogen- and progestin-based drugs for emergency contraception or progestin-based drugs for emergency contraception; and Ulipristal acetate for emergency contraception*

The following is a list of examples of preventive care services. For a full list of the most up-to-date preventive services, visit the websites listed in the Explanation and Limitations section below:

• *Physical exam, screening lab and x-rays* • *Well child visits* • *Adult/child routine immunizations* • *Mammogram – annual screening (2-D or 3-D)** • *Colorectal cancer screening***	• *Human Papillomavirus vaccine (NRS 695G.171)* • *Pelvic exam/Pap smear/breast exam* • *Prostate screening (NRS 695G.177)* • *Hypertension screening* • *Routine hearing exam*	• *Skin Cancer screening* • *Osteoporosis screening* • *Healthy Diet/Physical Activity Counseling**** • *Obesity Screening and Counseling*	• *Depression Screening* • *Breastfeeding support* • *Prenatal obstetrical office visits* • *Smoking/tobacco cessation*

Benefit Description	In-Network	Out-of-Network
Preventive Care/Wellness Benefits	Plan pays 100%, not subject to Deductible	Not Covered

Explanations and Limitations

Preventive Care/Wellness Benefits

Many preventive care services are provided as part of physical exams. These include regular checkups and well-child exams. Routine gynecologic examination (one per Plan Year), including annual cytologic screening test (Pap smear) for women 18 years of age or older, pelvic examination, urinalysis, and breast examination. Preventive care focuses on evaluating your current health status when you are symptom free and allows you to obtain early diagnosis and treatment to help avoid more serious health problems. During your preventive care visit, your doctor will determine what tests, health screenings and immunizations are right for you based on many factors such as your age, gender, overall health status, personal health history and your current health condition. Your physician may recommend a preventive service that is not listed in this document. For additional information regarding preventive benefit information, contact the third-party claims administrator listed in the *Participant Contact Guide*.

Preventive care services identified through the following links is recommended services. It is up to the participant and their physician or provider of care to determine which services to provide. Unless otherwise mandated by the Patient Protection and Affordable Care Act (PPACA), IRS rules and regulations for HSAs, or in accordance with applicable Nevada Revised Statutes, the Plan Administrator has the authority to determine which services, including frequency and quantity limits will be covered at the 100% wellness benefit.

This Plan covers recommended preventive care services with no cost sharing when provided by In-Network providers. Preventive Care Services are not subject to and will not apply to the Plan Year Deductible or Out-of-Pocket Maximum. Some preventive care services do have service quantity limitations.

Routine lab services from independent labs may not be paid as wellness unless the TPA system finds a corresponding wellness office visit within a reasonable number of days prior or after lab date to validate wellness diagnosis.

Human Papillomavirus testing and vaccination under NRS 695G.171.

*Mammogram: Preventative The first 2-D or 3-D mammograms of the Plan Year is are covered at 100% for women age 40 years and older under the Affordable Care Act and USPSTF,, regardless of diagnosis, or beginning at age 35 for members with a high-risk of breast cancer, when performed in-network. **Colorectal cancer screening: For adults aged 45 years and older who are at average risk of colorectal cancer in accordance with the American Cancer Society's qualified recommendations; or beginning at age 40 for members with a high-risk of colorectal cancer.

***Healthy Diet and Physical Activity for Cardiovascular Disease Prevention in Adults With Cardiovascular Risk Factors: Behavioral Counseling Interventions for adults aged 18 years and older are covered under the Wellness/Preventive Benefit when referred by a primary care practitioner; for those who have a basal

Benefit Description	In-Network	Out-of-Network
Preventive Care/Wellness Benefits	Plan pays 100%, not subject to Deductible	Not Covered

metabolic index (BMI) of 30 or greater; and have additional cardiovascular disease (CVD) risk factors. This wellness/preventive benefit is limited to twelve (12) Healthy Diet/Physical Activity Counseling or Obesity Screening/Counseling visits per Plan Year according to recommendations from the USPSTF. Additional visits are subject to deductible and co-insurance.

Smoking/Tobacco Cessation:

- Prescription and over-the-counter smoking/tobacco cessation products are covered under the prescription drug program. Over-the-counter smoking cessation products must be accompanied by a prescription written by a physician.
  - Some examples of cessation products eligible to be paid at 100% include Chantix (by prescription only), nicotine gum, nicotine patches, and nicotine lozenges.
    Some limitations on quantity may apply and are at the discretion of the Pharmacy Benefit Manager and your physician.
- Benefits for over-the-counter products are limited to those that are FDA approved and recommendations by the Surgeon General.
- Over-the-counter smoking/tobacco cessation products may be obtained by presenting your physician's written prescription to an In-Network pharmacy, or you can submit your purchase receipt for the product with your physician's written prescription attached to the Prescription Drug Reimbursement Claim Form (this form is located at www.pebp.state.nv.us).
- Second-line therapies such as clonidine hydrochloride and nortriptyline hydrochloride are sometimes used in the management of smoking/tobacco-cessation; however, due to the lack of an FDA-approved indication for smoking cessation, as well as undesirable side effect profiles, currently prohibit these agents from achieving first-line classification and therefore, not covered under the *Preventive Care/Wellness Services* Benefit.
- The Plan does not cover electronic cigarettes.

For more information, please visit or contact the third-party claims administrator.
Preventive Services for Adults and Families: Visit the U.S. Preventive Services Task Force at *https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/*

Preventive Services for Women, Including Pregnant Women: Visit Human Resources & Services Administration (HRSA) at *https://www.hrsa.gov/womens-guidelines/index.html*

Vaccines & Immunizations for infants, children, teens, and adults: Visit the U.S. Department of Health & Human Services at *https://www.cdc.gov/vaccines/index.html*

Preventive Health Services: Visit HealthCare.gov at *https://www.healthcare.gov/coverage/preventive-care-benefits/*

American Cancer Society /Colorectal Screening: *https://www.cancer.org/*

Preventive screening services are provided in accordance with national organizations, state, and federal laws:

- *United States Preventive Services Task Force (USPSTF) A & B Recommendations*

Benefit Description	In-Network	Out-of-Network
Preventive Care/Wellness Benefits	Plan pays 100%, not subject to Deductible	Not Covered

- *Section 2713(a)(5) of the Public Health Service Act*
- *Patient Protection and Affordable Care Act of 2010 (PPACA);*
- *Health Resources and Services Administration (HRSA);*
- *Centers for Disease Control (CDC);*
- *Advisory Committee on Immunization Practices (ACIP);*
- *Health and Human Services (HHS);*
- *as mandated by Nevada Revised Statute;*
- *and as mandated by federal law*

This Plan complies with NRS 695G as related to contraceptive methods, utilization management, step therapy, precertification, categorization of prescription drugs (meaning Preferred Generic, Preferred Brand and Non-Preferred Brands), and cost-sharing.

Benefit Description	In-Network	Out-of-Network
Radiology (X-Ray), Nuclear Medicine & Radiation Therapy Services (Outpatient)	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible

Explanations and Limitations

Radiology (X-Ray), Nuclear Medicine & Radiation Therapy Services (Outpatient)

The Plan covers medically necessary specialty radiology when ordered by a physician or health care practitioner acting with the scope of their license, including MRI, MRA, MRS MRT, PET, SPEC, and CT scan. Precertification required for CT, MRI, SPECT and PET. For other precertification requirements, see the *Utilization Management* (Prior Authorization) section.

The Plan covers technical and professional fees associated with:

- diagnostic and curative services, including radiation therapy, and
- pre-admission testing: Outpatient radiology tests performed 7 days prior to a scheduled hospital admission or outpatient surgery. The testing must be related to the sickness or injury for which admission or surgery is planned.

Refer to the *Preventive Care/Wellness Services* section of this document for information regarding benefits for screening radiology services and other preventive radiology testing.

Benefit Description	In-Network	Out-of-Network
Mastectomy and Reconstructive Services and Breast Reconstruction after Mastectomy	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible

Explanations and Limitations

Reconstruction Services and Breast Reconstruction after Mastectomy

This Plan complies with the Women's Health and Cancer Rights Act of 1998 (WHCRA) Breast reconstructive surgery and the internal or external prosthetic devices are covered for members who have undergone mastectomies or other treatments for breast cancer. Treatment will be provided in a manner determined in consultation with the physician and the member. For any covered individual who is receiving mastectomy-related benefits, coverage will be provided for:

- All stages of reconstruction of the breast on which the mastectomy has been performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- External prostheses that are needed before or during reconstruction; and
- Treatment of physical complications of all stages of the mastectomy, including lymphedema (fluid build-up in the arm and chest on the side of the surgery). Treatment of leaking breast implant is covered when the breast implant surgery was performed for reconstructive services following a partial or complete mastectomy as mandated by the Women's Health and Cancer Rights Act.

Prophylactic surgery is covered when prior authorized by the UM company.

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See also the *Exclusions* sections related to cosmetic services including reconstructive surgery.

Benefit Description	In-Network	Out-of-Network
Real Appeal	No cost to Participants	Not Covered

Explanations and Limitations

Nevada Public Employees' Benefits Program has partnered with UMR's Real Appeal program. Real Appeal provides eligible members a benefit for virtual weight loss and weight management coaching sessions. Sessions are covered under the preventive care benefit resulting in no cost-share to members. Real Appeal supports members eighteen (18) years of age and older.

This support includes, but not limited to, one-on-one coaching and online group sessions with supporting video content delivered by a virtual coach.

A qualified enrolled member will receive:

- Access to a coaches who will guide you through the program and develop a custom plan that fits your needs, preferences, and goals.
- 24/7 access to digital tools and dashboards.
- A Real Appeal kit containing health weight management tools that may include fitness guides, recipes, digital food and weight scales

Benefit Description	In-Network	Out-of-Network
Real Appeal	No cost to Participants	Not Covered

Explanations and Limitations

Nevada Public Employees' Benefits Program has partnered with UMR's Real Appeal program. Real Appeal provides eligible members a benefit for virtual weight loss and weight management coaching sessions. Sessions are covered under the preventive care benefit resulting in no cost-share to members. Real Appeal supports members eighteen (18) years of age and older.

- Support from online group classes with a coach and other members who share what's helped them achieve success.

For more information, contact the Plan's third-party claims administrator listed in the Participant Contact Guide.

Benefit Description	In-Network	Out-of-Network
Rehabilitation Services (Cardiac, Physical, Occupational, and Speech Therapy)	Inpatient or Outpatient: Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible

Explanations and Limitations

Rehabilitation Services (Physical, Occupational, and Speech Therapy)

- Rehabilitation services are covered only when ordered by a physician or other provider acting within the scope of their license.
- Inpatient rehabilitation admission requires prior authorization.
- Prior authorization for outpatient rehabilitative and habilitative therapy (occupational, physical, or speech) exceeding 90 combined visits per Plan Year (limit not applied to therapy treating a behavioral health condition).
- There is no limit for Cardiac Rehabilitation services.
- Benefits for rehabilitation therapy are limited to services given for acute or recently acquired conditions that, in the judgement of the member's physician are subject to significant improvement through short-term therapy.
- Short term active, progressive rehabilitation services for occupational, physical, or speech therapy must be performed by a licensed or duly qualified therapist/provider acting within the scope of their license.
- Inpatient rehabilitation services in an acute hospital, rehabilitation unit or facility or skilled nursing facility for short term, active, progressive rehabilitation services that cannot be provided in an outpatient or home setting.
- Maintenance Rehabilitation and coma stimulation services are not covered (see specific exclusions relating to rehabilitation therapies in the *Exclusions* section).
- Speech therapy is covered if the services are provided by a licensed or duly qualified speech therapist to restore normal speech or to correct dysphagia, swallowing defects, to correct speech disorders due to childhood developmental delays and disorders due to illness, injury, or a surgical

Benefit Description	In-Network	Out-of-Network
Rehabilitation Services (Cardiac, Physical, Occupational, and Speech Therapy)	Inpatient or Outpatient: Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible

Explanations and Limitations

Rehabilitation Services (Physical, Occupational, and Speech Therapy)

procedure. Speech therapy is payable following surgery to correct a congenital condition of the oral cavity, throat, or nasal complex (other than a frenectomy), an injury, or sickness that is other than a learning or mental disorder.

See the see the *Utilization Management* section for prior authorization requirements.

Benefit Description	In-Network	Out-of-Network
Second Physician Opinion Includes only one office visit per opinion	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible

Explanations and Limitations

Second Physician Opinion

For your second opinion, you may choose any In-Network, Board-certified specialist who is not an associate of the attending physician.

Benefit Description	In-Network	Out-of-Network
Skilled Nursing Facility (SNF) and Subacute Care Facility	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible

Explanations and Limitations

Skilled Nursing Facility (SNF) and Subacute Care Facility

- Admission to a skilled nursing facility or subacute care facility must be ordered by a physician and requires prior authorization (see the *Utilization Management* section of this document).
- Skilled nursing facility (SNF) confinement or subacute care facility confinement payable up to 60 days per Plan Year for all confinements related to the same cause.
- Additional visits are subject to preauthorization by the UM Company

Benefit Description	In-Network	Out-of-Network
Enteral Formula and Special Food Product Inherited Metabolic Disease	Plan pays 80% after Plan Year Deductible; Maximum benefit $2,500 per Plan Year for Special Food Products	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible; Maximum benefit $2,500 per Plan Year for Enteral Formula

Explanations and Limitations

Special Food Product and Enteral Formula for Inherited Metabolic Disease

Enteral Formulas and Special Food Products are covered in accordance with NRS 689B.0353.

Documentation to substantiate the presence of an inherited metabolic disease, including the documentation that the product purchased is a Special Food Product or Enteral Formula may be required before the Plan will reimburse for the cost associated with Special Food Products or Enteral Formulas.

Benefit Description	In-Network	Out-of-Network
2nd.MD (Second Opinion Service)	Plan Pays 100%, not subject to Deductible	Not Covered
Telemedicine **Doctor on Demand (DoD) only**		Not Covered
Medical Visit	$49, after Deductible	Not Covered
Psychology Visit (25-minute visit)	$79 , after Deductible	Not Covered
Psychology Visit (50-minute visit)	$129, after Deductible	Not Covered
Psychiatry Visit (initial 45-minute visit)	$229, after Deductible	Not Covered
Psychiatry Visit (15-minute follow-up visit)	$99, after Deductible	Not Covered
Telehealth (other telemedicine providers)	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible

Explanations and Limitations

Telemedicine and Telehealth

- Doctor on Demand telemedicine services is PEBP's contracted telehealth provider and are considered In-Network. To learn more, visit http://www.doctorondemand.com/pebp.

- 2nd.MD provides eligible members with direct access to elite specialists across the county for expert second opinions. Specialists answer questions about disease, cancer, chronic conditions, surgery or procedure, medications, and treatment plans. All specialists are board certified, leaders in

research, and pioneers in medicine. To learn more visit www.2nd.MD/PEBP or call 1-866-841-2575.

- Alternatively, telemedicine may be available from in-network providers and is covered on the same basis as in-person services. It is your responsibility to ensure the providers you use are in-network providers. Failure to use in-network providers will result in a denial of benefits and higher cost to you

- This Plan also adheres to the provisions of NRS 695G.162 regarding telehealth.

Benefit Description	Center of Excellence	Non-Center of Excellence
Transplant Services (Organ, and Tissue)	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible

Explanations and Limitations
Transplants (Organ and Tissue)

- Coverage is provided only for eligible services directly related to non-experimental transplants of human organs or tissue, along with the facility and professional services, FDA-approved drugs, and medically necessary equipment and supplies.
- Coverage is provided for the donor when the receiver is a participant under this Plan. Coverage is provided for organ or tissue procurement and acquisition fees, including surgery, storage, and organ or tissue transport costs directly related to a living or nonliving donor (transport within the U. S. or Canada only). When the donor has medical coverage, his or her plan will pay first and the benefit under this Plan will be reduced by the amount payable by the donor's plan.
- Expenses incurred by a participant of this Plan who donates an organ or tissue are not covered unless the person who receives the donated organ/tissue is also a participant covered by this Plan.
- Transplantation-related services require precertification (see the *Utilization Management* section of this document for details). Coverage is provided only for eligible services directly related to non-experimental transplants of human organs or tissue, along with the facility and professional services, FDA-approved drugs, and medically necessary equipment and supplies.
- See the *Exclusions* section related to experimental and investigational services and transplants.
- To receive maximum Plan benefits, members must use a Center of Excellence for single organ or combined organs and tissue transplants. Transplant Center of Excellence facilities will be identified by the claim's administrator. For information regarding transplant benefits and Centers of Excellence facilities, contact the third-party claims administrator at 888-763-8232.
- This Plan provides for reimbursement of certain costs associated with travel and hotel accommodations for the patient and one additional person (spouse/domestic partner, family member or friend) when associated with medical treatment for organ and tissue transplants performed at a Center of Excellence. For travel expense benefits, refer to the *Travel Expenses* section.
- Expenses incurred for travel and hotel accommodations for organ and/or tissue transplants not performed at a Center of Excellence are not covered.
- PEBP does not provide advance payment for travel expenses related to organ or tissue transplants.

Benefit Description	
Travel Expenses	Subject to IRS Limitations under Publication 502 and Code 213(d) Subject to Deductible and Out-of-Pocket Maximum

Explanations and Limitations

Travel Expenses

This Plan allows for the reimbursement of certain travel and hotel accommodation expenses permitted under IRS Regulation 213(d) and IRS Publication 502 for qualified medical expenses for the member and one additional person (travel companion) when the expenses are associated with the following services, have been prior authorized by the UM company, and when the member resides 50 or more miles from the provider location:

- Organ and tissue transplants or bariatric weight loss surgery performed at a Center of Excellence.
- Elective surgeries performed as exclusive hospitals/ambulatory facilities and
- Outpatient infusion services performed at exclusive outpatient infusion centers.
- Travel for a participant located in a State with restricted access to abortion to the nearest care center for abortion services covered under this Plan.

Travel expenses are covered when incurred in conjunction with the member's:

- Transplant or bariatric surgery (does not include pre-surgery evaluations) and for one year after surgery for follow-up visits as required by the patient's surgeon. Travel expenses incurred on or after one year are not eligible for reimbursement.
- Hip and knee total joint replacement surgery performed at an approved exclusive Nevada hospital/ ambulatory surgery facility when prior authorized by the utilization management company (including pre-surgery evaluations) and for one year after surgery for follow-up visits as required by the patient's surgeon; and
- Travel expenses related to an organ or tissue transplant, or bariatric surgery scheduled or performed at a facility or other provider type that is not a Center of Excellence as determined by the Plan Administrator or its designee will not be covered. Travel expenses related to an inpatient or outpatient surgery that is not determined to be a preferred hospital/ambulatory surgical facility by the UM company will not be covered. There are no exceptions.
- If the travel companion has their own separate PEBP Plan, travel expense reimbursement will not apply to the companion.
- PEBP does not provide advance payment for travel expenses.
- This Plan incorporates the travel expense reimbursement guidelines established in IRS Regulation 213(d) and IRS Publication 502.
- The least expensive method of transportation must be used.
- Standard mileage reimbursement for the use of a personal vehicle to travel to a Center of Excellence or to an exclusive hospital/ambulatory surgical facility or outpatient infusion center is based on the mileage from the member's residence to and from the facility (based on an objective source such as Google Maps).
- The Plan Administrator or its designee has full authority to approve or deny all or part of the travel expenses. The reduction and/or denial of travel expenses cannot be appealed.

Benefit Description	
Travel Expenses	Subject to IRS Limitations under Publication 502 and Code 213(d) Subject to Deductible and Out-of-Pocket Maximum

Explanations and Limitations

Travel Expenses

- Travel expenses subject to Deductible and Out-of-Pocket Maximum.

Excluded travel expenses:

The following are specifically excluded from reimbursement under any circumstances (other expenses not included below may be denied if they are not preapproved):

- Alcoholic beverages.
- Car maintenance.
- Vehicle insurance.
- Flight insurance.
- Cards, stationery, stamps.
- Clothing.
- Dry cleaning.
- Entertainment (cable televisions, books, magazines, movie rentals).
- Flowers.
- Household products.
- Household utilities, including cell phone charges, house cleaner, baby-sitter, or day care services.
- Kennel fees.
- Laundry services.
- Meals (insomuch as it is excluded under the IRS Publication 502 and Regulations under 213(d).
- Security deposits.
- Toiletries.
- Travel expenses related to a facility or provider that is not a certified Center of Excellence, exclusive hospital/ambulatory surgical facility, or outpatient infusion facility; and
- Travel expenses incurred on or after one year following surgery are not eligible for reimbursement.
- Travel expenses are subject to the annual cost sharing requirements.

Pre-approval for travel expenses:

- Travel expenses must be pre-approved by PEBP or its designee
    - If the member is unable to obtain pre-approval because the organ or tissue transplant required immediate travel, the member may submit travel costs to PEBP or its designee after the transplant surgery.
    - Pre-approval will provide an estimation of your travel reimbursement. A Travel Pre-Authorization form is available at www.pebp.state.nv.us.

Submitting Travel Reimbursement form and receipts:

Benefit Description	
Travel Expenses	Subject to IRS Limitations under Publication 502 and Code 213(d) Subject to Deductible and Out-of-Pocket Maximum

Explanations and Limitations
Travel Expenses

- Requests for travel expense reimbursement must be submitted to PEBP using the Travel Reimbursement form available at www.pebp.state.nv.us.
- Travel Reimbursement forms and receipts must be submitted within 12 months of the date of the surgery/procedure.
    - The form must be completed, including the start and end times, destination, and purpose of trip
    - Must include original itemized receipts identifying the name(s) of the person(s) incurring the expense.

Reimbursement of eligible travel expenses, including any relating to a travel companion, will be payable to the primary participant.

Reimbursement will be based on actual expenses incurred and the actual number of days and travel times and may differ from the pre-approval estimation.

Benefit Description	In-Network	Out-of-Network
Vision Screening Exam	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible

Explanations and Limitations
Vision Screening Exam*

- One annual preventive vision screening exam including refractive error testing per Plan Year.
- Hardware such as but not limited to contact lenses, lenses and frames are not covered.
- *When refraction is conducted in conjunction with an examination with a medical diagnosis, such as cataracts, it will be paid under the medical benefit, subject to Deductible and Coinsurance.
- PEBP does not maintain a network specific to vision care; however, the PPO network does have a list of some vision providers.

Schedule of Prescription Drug Benefits

Benefits for prescription drugs are provided through the prescription drug plan administered by the Pharmacy Benefit Manager, Express Scripts ("ESI"). Coverage is provided only for those pharmaceuticals (drugs and medicines) obtained from In-Network providers and approved by the U. S. Food and Drug Administration (FDA) as requiring a prescription and FDA approval for the condition, dose, route, duration, and frequency, if prescribed by a physician or other practitioner.

The following schedule includes explanations and limitations that apply to each benefit; however, the explanations and limitations may not include every limitation. For more information relating to a specific benefit, refer to *Utilization Management* (for any precertification requirements), *Exclusions*, *Key Terms and Definitions* and other sections that may apply to a specific benefit.

For helpful tools such as "Price a Medication" see the *Participant Contact Guide* section or go to the PEBP website at *www.pebp.state.nv.us.*

Benefit Description	In-Network	Out-of-Network
Prescription Drug Benefits		
Preferred/Formulary Generic Drugs	Plan pays 80% after Plan Year Deductible	Not Covered
Preferred/Formulary Brand Drugs	Plan pays 80% after Plan Year Deductible	Not Covered
Non-Preferred/Non-Formulary Brand Drugs	You pay 100% of the cost of the medication; Deductible and Out-of-Pocket Maximum credit is not applied	Not Covered
Specialty Pharmaceutical Drug (Accredo Specialty Pharmacy)	Plan pays 80% after Plan Year Deductible	Not Covered
Preventive Medications (Limited only to those preventive drugs identified by the pharmacy benefit manager)	ACA Mandated Preventive Drugs: Plan Pays 100%, not subject to Plan year Deductible Other Preventive Drugs: Plan pays 80%, not subject to Plan Year Deductible	Not Covered
Explanations and Limitations Prescription Drug Benefit This Plan does not coordinate prescription drug plan benefits.		

Benefit Description	In-Network	Out-of-Network

Prescription Drug Benefits

Some over the counter (OTC) drugs and prescription drugs are eligible to be covered under the Plan's *Preventive Care/Wellness Services* benefit in accordance with the Affordable Care Act; whereby, the Plan will waive the Copays and Deductibles and products are paid at 100%. Please contact Express Scripts for more information.

Certain OTC female contraception products are covered when presented with a prescription from your physician to your pharmacy. These types of products include the female condom, sponges, and spermicides. Refer to the *Women's Preventive Care/Wellness Services* section for more information or call Express Scripts, whose contact information is in the *Participant Contact Guide*.

Many vaccines may also be administered through the prescription drug benefit with certain pharmacies. Contact the Pharmacy Benefit Manager listed in the *Participant Contact Guide* or visit www.express-scripts.com to check vaccine coverage and locate your nearest In-Network pharmacy. Contact the pharmacy to verify their current vaccination schedule and vaccine availability.

Coverage is also provided for, but not limited to:

- Vaccinations such as shingles, HPV, Flu, pneumonia, Herpes Zoster, TDAP (whooping cough)
- Prenatal & pediatric prescription vitamins
- Prescription female oral contraceptives
- Insulin, diabetic supplies (such as lancets, syringes, test strips), insulin pumps, and insulin pump supplies.
  - insulin pumps and supplies are covered under the pharmacy benefit's base day and quantity limits, subject to copayments, deductibles, or coinsurance.
- Orally Administered Chemotherapy (NRS 695G.167): The Copayment, after deductible, or Coinsurance amount for orally administered chemotherapy drugs will be consistent with the drug's formulary tier for retail, home delivery and Specialty pharmacy; and in accordance with NRS 695G.167, the cost will not exceed $100 per prescription for a 30-day supply. For more information, see *Key Terms and Definitions* section.
- Chronic medication synchronization per NRS 695G.1665
- This Plan also complies with NRS 695G.172, regarding coverage of topical ophthalmic product.
  - Refills of topical ophthalmic products will be covered when medically necessary, including when requested: (a) After 21 days or more but before 30 days after receiving any 30-day supply of the product; (b) After 42 days or more but before 60 days after receiving any 60-day supply of the product; or (c) After 63 days or more but before 90 days after receiving any 90-day supply of the product.
- Medically necessary prescription drugs to treat sickle cell disease and its variants (NRS 695G.174).
- Human Papillomavirus testing and vaccination under NRS 695G.171.

Preventive Drug Benefit Program

The Preventive Drug Benefit Program provides participants access to certain preventive drugs without having to meet a Deductible and will instead only be subject to Coinsurance. Coinsurance paid under the benefit will not apply to the Deductible but will apply to Out-of-Pocket Maximum costs. The medications covered under this benefit are limited to those preventive drugs identified by Express Scripts. Preventive drugs include categories of prescription drugs that are used for preventive purposes for conditions such as hypertension, asthma, and high cholesterol. A list of eligible preventive drugs covered under this benefit can be found by logging on to www.pebp.state.nv.us or by contacting Express Scripts located in the *Participant Contact Guide* section.

The plan adheres to NRS 695G.1715 regarding contraception and related health services.

Specialty Drugs

Specialty drugs are used to treat complex conditions, such as cancer, hemophilia, hepatitis C, immune deficiency, multiple sclerosis, rheumatoid arthritis, etc. Certain drugs fall into a category called specialty drugs. Specialty drugs and prescriptions are generally limited to a 30-day supply. Specialty drugs are available only through the Accredo, the Plan's Specialty Pharmacy. Check with Express Scripts to determine if your prescription is considered specialty (see the Participant Contact Guide).

Certain drugs fall into a category called specialty drugs. Specialty drugs are available only through the Specialty Pharmacy listed the *Participant Contact Guide* section, and prescriptions are limited to a 30-day supply. Plan participants are encouraged to register with the Specialty Pharmacy before filling their first prescription for a specialty drug. Contact Express Scripts to determine if your prescription is considered specialty.

Special pharmaceuticals, which include injectables, oral medications, and medications given by other routes of delivery, may be delivered in any setting. Special pharmaceuticals are pharmaceuticals that typically have:

- Limited access.
- Treat complex medical conditions.
- Complicated treatment regimens.
- Compliance issues.
- Special storage requirements; or
- Manufacturer reporting requirements.

This Plan's Pharmacy Benefit Manager maintains a list of special drugs classified as special pharmaceuticals. For information regarding special pharmaceuticals, contact the Pharmacy Benefit Manager listed in the *Participant Contact Guide*.

Preferred Retail Pharmacy Network

For short-term prescriptions, such as antibiotics, use a Preferred Retail Pharmacy (for lower copays) or a Non-Preferred Retail Pharmacy (where you will pay $10 extra for each short-term prescription). Your Preferred Retail Pharmacy Network has more than 34,000 pharmacies consisting of

Benefit Description	In-Network	Out-of-Network
Prescription Drug Benefits		

approximately 50% independent pharmacies in addition to grocers and other stores. To find a preferred pharmacy near you, register or log in to express-scripts.com/findapharmacy or call Express Scripts' Member Services at 855-889-7708.

Smart90 Retail and Home Delivery Program

The Smart90 program is a feature of your prescription plan, managed by Express Scripts. With this program, you have two ways to get up to a 90-day supply of your long-term medications (those you take regularly for ongoing conditions). You can fill your long-term prescriptions through home delivery from the Express Scripts Home Delivery Pharmacy or at a retail pharmacy in the Smart90 network.

You will need to move your long-term medications to both a 90-day supply and to either a participating retail pharmacy or Express Scripts Home Delivery Pharmacy. If, after your second 30-day supply courtesy fill of your long-term medication, you do not make the switch you will pay a higher cost for your prescription medication and will not receive credit toward your Deductible or Out-of-Pocket Maximum.

Smart90 Retail Pharmacy

To locate a participating Smart90 Retail Pharmacy or a Preferred Retail Network Pharmacy, log in to the E-PEBP Portal located at www.pebp.state.nv.us and select *Express Scripts*. You can also get pharmacy information by calling Express Scripts' Member Services at 855-889-7708. You can transfer your medications easily in-store, by phone or online.

Express Scripts Home Delivery

You may use home delivery through the Express Scripts Home Delivery Pharmacy to receive a 90-day supply of your maintenance medications and have them mailed to you with free standard shipping. Not all drugs are available via mail order. Check with Express Scripts for further information on the availability of your prescription medication. Enrolling in home delivery is easy! First, log in to express-scripts.com.

If you are enrolling a new prescription in home delivery:

- **Contact your doctor** and ask them to e-prescribe a 90-day prescription directly to Express Scripts
- OR **send a request** by selecting "Forms" or "Forms & Cards" from the "Benefits" menu, print and mail-order form and follow the mailing instructions
- OR **call Express Scripts'** Member Services at 855-889-77058 and they will contact your doctor for you if you are enrolling a current prescription:

Transfer retail prescriptions to home delivery by clicking "Add to Cart" for eligible prescriptions and check out. You can also refill and renew prescriptions. Express Scripts will contact your doctor and take care of the rest.

Benefit Description	In-Network	Out-of-Network

Prescription Drug Benefits

Check Order Status to track the shipping of your prescriptions. Please allow up to 14 days. Please keep in mind, longer delivery times may be due to additional correspondence need with prescribers, medication availability and/or delivery times from the shipping vendor.

Generics Preferred Program

When your doctor prescribes a brand-name drug and a generic substitute is available, you will automatically receive the generic drug unless:
Your doctor writes "dispense as written" (DAW) on the prescription; or
You request the brand-name drug at the time you fill your prescription.

If you choose generic medicines, you get safe medicines at lower cost. Your cost for the generic drug will be less than the cost for the brand-name drug.

If a generic is available, but you or your doctor request the brand-name drug, you will pay the applicable brand cost.

Payment assistance (manufacturer-funded patient assistance) for specialty drugs will not apply toward your Deductible and Out-of-Pocket Maximum.

SaveonSP Program

As part of your prescription drug plan, Nevada Public Employees' Benefits Program has partnered with an Express Scripts' cost assistance program, SaveonSP, to help save money on certain specialty medications. Through the SaveonSP Program, manufacturer-funded assistance is available to help assisting members with the cost of the Program drug(s) is reimbursed by the manufacturer at no cost to the participant.

The medications included in the SaveonSP Program are classified as Non-Essential Health Benefits under the Affordable Care Act. The cost of these drugs will not be applied towards satisfying your deductible or out-of-pocket maximum.

Members currently taking a medication or those who will be taking a medication that is on the *Non-Essential Benefit Specialty Drug List*, are eligible to participate in the program.

- Select medications on the *Non-Essential Benefit Specialty Drug List* will be free of charge ($0) to members who participate.
- Prescriptions must be filled through Accredo Specialty Pharmacy.
- The medications and associated cost included in this program are subject to the Pharmacy Benefit Manager's clinical rules.
- If the medication you are taking is on the SaveonSP *Non-Essential Benefit Specialty Drug List* and you wish to participate, call SaveonSP at 1-800-683-1074.

Benefit Description	In-Network	Out-of-Network
Prescription Drug Benefits		

Participation in the SaveonSP Program is voluntary; however, if you are taking or will be taking a medication that is on the Non-Essential Benefit Specialty Drug List, and you choose not to participate in the SaveonSP Program, you will be responsible for the cost of the medication and the cost will not apply toward your Deductible or Out-of-Pocket Maximum.

Hinge Health Digital Musculoskeletal (MSK) Care program

Hinge Health's Digital MSK Program is offered through Express Scripts' and is designed to help members with Musculoskeletal Care using digital technology. The program offers qualifying participants virtual physical therapy focusing on prevention, acute injury, chronic and surgical care programs via digital physical therapy plus additional physical and behavioral support through a full clinical-care team. Members will also have access to other services, such as, pelvic floor therapy, advanced wearable technology for electrical nerve stimulation and pain relief, expert medical opinion consultation, health education, etc.

Members will complete a screener to assess which Digital MSK ClinicTM programs is right for them. The questionnaire screener leverages data analytics combined with a dedicated clinical care team review to match each member's personal needs with the right program tools and resources. This program is managed by Express Scripts and is provided at no cost to members.

Diabetic Medications and Supplies

Participants who enroll and participate in PEBP's Diabetes Care Management Program may receive up to a 90-day supply of preferred diabetic supplies and the cost of those supplies will not be subject to annual Deductible or Coinsurance requirements. Diabetic supplies under this program must be filled through Express Scripts Home Delivery pharmacy and include blood glucose monitors, test strips, insulin, syringes, alcohol pads, and lancets. For more information contact Express Scripts' Member Services at 855-889-7708.

Extended Absence Benefit

If you are going to be away from your home for an extended period, either in the country or outside of the country, you may obtain an additional fill (30 or 90-day supply) of your prescription drugs from your local retail or mail order pharmacy. This limited benefit must be requested in advance by the participant to the prescription drug Plan Administrator listed in the *Participant Contact Guide*. A maximum of two (2) early refills are allowed every 180 days. You may be required to obtain a new written prescription from your physician and any necessary prior authorizations.

Out-of-Country Emergency Medication Purchases

This Plan may cover emergency prescription drugs purchased if you reside in the United States and travel to a foreign country. You will need to pay for the drug at the time of purchase and later submit

Benefit Description	In-Network	Out-of-Network
Prescription Drug Benefits		

for reimbursement from the Pharmacy Benefit Manager. Prescription drug purchases made outside of the United States are subject to Plan provisions, limitations and exclusions, clinical review, and determination of medical necessity. The review will also include regulations determined by the FDA. Out-of-Country medication purchases are only eligible for reimbursement while traveling outside of the United States.

If your purchase is eligible for reimbursement, you must use the Direct Claim Form available from the prescription drug Plan Administrator. Direct Claim Forms may be requested from the prescription drug plan or obtained by logging in to www.express-scripts.com. In addition to the Direct Claim Form, you are required to provide:

- A legitimate copy of the written prescription completed by your physician.
- Proof of payment from you to the provider of service (typically your credit card invoice).
- Prescription and receipt must be translated to English and include the American equivalent National Drug Code for the prescription purchased.
- Reimbursement request must be converted to United States dollars.

Any foreign purchases of prescription medications will be subject to Plan limitations such as:

- Benefits and coverage
- Deductibles
- Coinsurance
- Dispensing maximums
- Annual benefit maximums
- Medical Necessity
- Usual and Customary (U&C) or prescription drug pharmacy benefit manager contracted allowable
- FDA approval
- Plan prior authorization requirements

Contact the Express Scripts before traveling or moving to another country to discuss any criteria that may apply to a prescription drug reimbursement request.

Out-of-Network Pharmacy Benefit

Prescriptions filled at a domestic (inside the United States) out-of-network pharmacy location, are not authorized for reimbursement under the prescription drug Plan. Prescription drugs must be filled at a participating in-network pharmacy location.

Benefit Description	In-Network	Out-of-Network
Prescription Drug Benefits		
Other Limitations: • This Plan does not coordinate prescription drug plan benefits with other prescription drug plans. It is the participant's responsibility to use the appropriate primary and secondary (if applicable) prescription plan. • See exclusions related to medications in the *Exclusions* section of this document. • The formulary is maintained by the Pharmacy Benefit Manager and may be subject to change according to the Pharmacy Benefit Manager.		

Benefit Limitations and Exclusions

This Plan does not cover certain services. This chapter lists the general medical and pharmacy benefit exclusions of this Plan. Any amount you pay toward services that are not covered or otherwise excluded will not count toward your out-of-pocket maximum. Additional exclusions that apply to only a service or benefit are listed in the description of that service or benefit in the *Schedule of Medical Benefits* sections. This list is not all-inclusive; if you have questions about a service or supply, contact the Claims Administrator listed in the *Participant Contact Guide.*

Expenses That Do Not Accumulate Toward Your Out-of-Pocket Maximum

The following services do not accumulate toward the out-of-pocket maximum, and you will be responsible for paying these expenses out of your own pocket.

- All expenses for medical and pharmacy services and supplies that are not covered by the Plan, to include but not limited to, expenses that exceed the CDHP network contract rate, services listed in the *Benefit Limitations and Exclusions* section.
- All charges in excess of the usual and customary charge determined by the Plan Administrator.
- Any additional amounts you must pay because you failed to comply with the utilization management requirements described in the *Utilization Management* section.
- Benefits exceeding those services or supplies subject to maximum individual or lifetime limit(s) for certain eligible medical expenses as listed in the *Schedule of Medical Benefits*; and
- Certain wellness or preventive services that are paid by this Plan at 100% do not accumulate towards the out-of-pocket maximum.
- The value of manufacturer rebates for drugs on the SaveOnSP non-essential drug list.

This list is not all inclusive and may not include certain services and supplies that are not listed above.

Benefit Limitations

In addition to the exclusions listed below, refer to the *Schedule of Medical Benefits* sections for the maximum individual or lifetime limit(s) and any Plan Year limit applicable to certain covered expenses. Plan Year limits are met by days, hours, visits, or dollar limits paid under all components of the Plan.

Lifetime Maximum

This Plan imposes a lifetime maximum on some health care services and procedures. For information on the lifetime maximums, refer to the *Schedule of Medical Benefits* sections.

Exclusions Under the Medical Plan

The following is a list of services and supplies or expenses not covered by this Plan. The Plan Administrator and its designees will have discretionary authority to determine the applicability of these exclusions and terms of the Plan and determines eligibility and entitlement to Plan benefits. Any amount you pay toward services that are not covered or otherwise excluded will not count toward your out-of-pocket maximum.

Abortion: Elective termination of pregnancy (abortion) is excluded from the plan, other than medically indicated abortions that are medically necessary to save the life of the mother and complications of such abortions.

Alternative/Complimentary Health Care Exclusions: Expenses for chelation therapy (except as may be medically necessary for treatment of acute arsenic, gold, mercury, or lead poisoning) and for diseases due to clearly demonstrated excess of copper or iron. Expenses for prayer, religious healing, or spiritual healing, except services provided by a Christian Science Practitioner. Expenses for naturopathic, Naprapathy services or treatment/supplies. Expenses for homeopathic treatments/supplies that are not FDA approved.

Autopsy: Expenses for an autopsy and any related expenses, except as required by the Plan Administrator or its designee.

Bariatric and Overweight Surgery: The Plan's individual lifetime maximum is one (1) bariatric surgery while covered under any current or previous PEBP self-funded health plan.

Bariatric and Overweight Surgery Not Performed at a Center of Excellence Provider: Benefits are excluded for bariatric/weight loss surgery performed at an Out-of-Network facility, Out-of-Network surgeon, or when Out-of-Network ancillary providers are used, notwithstanding services covered under the No Surprises Act. PEBP or its designee will determine the In-Network Center of Excellence facility.

Behavioral Health Care Exclusions

- Expenses for hypnosis and hypnotherapy.
- Expenses for behavioral health care services related to: adoption counseling; non medically necessary court-ordered behavioral health care services (except pursuant to involuntary confinement under a state's civil commitment laws); custody counseling; dance, poetry, or art therapy; developmental disabilities; dyslexia; learning disorders; attention deficit disorders (with or without hyperactivity, except when the services are for diagnosis, the prescription of medication as prescribed by a physician or other health care practitioner, or when accompanied by a treatment plan as submitted to the Plan or its designee) or the treatment is related to the management of ADD/ ADHD without prescription drugs and is approved by the Plan or its designee; family planning counseling; marriage, couples and or sex counseling; intellectual disability; pregnancy counseling; vocational disabilities, and organic and non-organic therapies including (but

not limited to) crystal healing, EST, primal therapy, L-Tryptophan, vitamin therapy, religious/spiritual, etc.

- Expenses for tests to determine the presence of or degree of a person's dyslexia or learning disorder unless the visit meets the criteria for benefits payable for the diagnosis or treatment of Autism Spectrum Disorders.

Complications of a non-covered service: Expenses for care, services or treatment required because of complications from a treatment or service not covered under this Plan, except complications from an abortion.

Concierge membership fees: Expenses for fees described or defined as membership, retainer or premiums that are paid to a concierge medical practice to have access to the medical services provided by the concierge medical practice.

Clinical Trials: See ***Experimental and Investigational*** in the *Key Terms and Definitions* section.

Controlled Substance or Intoxicated: Services/treatment which involve an injury to which a contributing cause was the insured's commission of or attempt to commit a felony, except if a result of a medical or behavioral health condition, or domestic violence, even if the condition was not diagnosed at the time of the injury. See NRS 695G.405.

Corrective Appliance, Orthotic Device Expenses, and Appliances: Any items that are not corrective appliances, orthotic devices or orthotic braces that straighten or change the shape of a body part, prosthetic appliances, or durable medical equipment (as each of those terms is defined in the *Key Terms and Definitions s*ection), including, but not limited to, personal comfort items like air purifiers, humidifiers, electric heating units, swimming pools, spas, saunas, escalators, lifts, motorized modes of transportation, pillows, orthopedic mattresses, water beds, and air conditioners are excluded. Expenses for cranial helmets are excluded except for cranial helmets used to facilitate a successful post-surgical outcome. Expenses for replacement of lost, missing, or stolen, duplicate or personalized corrective appliances, orthotic devices, prosthetic appliances, or durable medical equipment are not covered. Oxygen provided while traveling on an airline and portable oxygen concentrators that are supplied for purchase or rent specifically to meet airline requirements are excluded.

Cosmetic Services and Surgery: The Plan excludes expenses for cosmetic services and surgery or any drugs used for cosmetic purposes, including but not limited to health and beauty aids.

Complications resulting from Cosmetic Services or Surgery are not covered.

There is no coverage for travel costs.

Prophylactic surgery is covered under certain circumstances. Contact the UM company.

Participants should use the Plan's precertification procedure to determine if a proposed surgery or service will be considered cosmetic surgery or medically necessary reconstructive services.

*Breast augmentation/augmentation mammoplasty excluded, except when the patient undergoing surgeries for gender dysphoria has received 12 continuous months of hormonal (estrogen) therapy and the breast tissue growth failed to result a Tanner Stage 5 on the puberty scale, as determined by the provider, or the recipient has a medical contraindication to hormone therapy. The Plan Administrator will determine authorization and consent to care based on medical necessity.

Costs of Reports, Bills, etc.: Expenses for preparing medical reports, bills or claim forms; mailing, shipping, or handling expenses; and charges for broken/missed appointments, general telephone calls not including telehealth, or photocopying fees.

Court-Ordered Treatment: Medical and psychiatric evaluations, examinations, or treatments, psychological testing, therapy, laboratory and other diagnostic testing and other services including hospitalizations or partial hospitalizations and residential treatment programs that are ordered as a condition of processing, parole, probation, or sentencing are excluded, unless the Plan Administrator or its designee determines that such services are independently medically necessary.

Custodial Care: Expenses for custodial care as defined in the *Key Terms and Definitions* section, regardless of where they are provided, including, without limitation, adult day care, child day care, services of a homemaker, or personal care, sitter/companion service, including any service that can be learned to be performed or provided by a family member who is not a physician, nurse or other skilled health care provider are not covered, even if they are medically necessary.

Services required to be performed by physicians, nurses or other skilled health care providers are not considered to be provided for custodial care services and are covered if they are determined by the Plan Administrator or its designee to be medically necessary. However, any services that can be learned to be performed or provided by a family member who is not a physician, nurse or other skilled health care provider are not covered, even if they are medically necessary.

Dental Services:

Expenses for dental prosthetics or dental services or supplies of any kind, even if they are necessary because of symptoms, congenital anomaly, illness, or injury affecting the mouth or another part of the body.

Except as described as an inclusion in the Schedule of Medical Benefits, services involving treatment to the teeth; extraction of teeth; repair of injured teeth; general dental services; treatment of dental abscesses or granulomas; treatment of gingival tissues (other than for tumors); dental examinations; restoration of the mouth, teeth, or jaws because of injuries from biting, chewing, or accidents; artificial implanted devices; braces; periodontal care or surgery; teeth prosthetics and bone grafts regardless of etiology of the disease process; and repairs and restorations except for appliances that are medically necessary to stabilize or repair sound and natural teeth after an injury; dental and or medical care including mandibular or maxillary surgery, orthodontia treatment, oral surgery, pre-prosthetic surgery, any procedure involving osteotomy to the jaw, and any other dental product or service except as set forth in the Schedule of Medical Benefits.

Coverage for dental services as the result of an injury to sound and natural teeth may be extended under the medical Plan to a maximum of two (2) years following the date of the injury. Restorations past the two-year time frame will be considered under the dental benefits described in the PEBP Self-Funded Dental PPO Plan Master Plan Document available at www.pebp.state.nv.us.

Treatment to the gums and treatment of pain or infection known or thought to be due to dental or medical cause and in close proximity to the teeth or jaw, braces, bridges, dental plates or other dental orthosis or prosthesis, including the replacement of metal dental fillings; and other supplies and services including but not limited to cosmetic restorations, implants, cosmetic replacements of serviceable restorations, and materials (such as precious metals).

Orthodontia is a specific Plan exclusion.

Drugs, Medicines, Nutrition or Devices:

- Pharmaceuticals requiring a prescription that have not been approved for use by the U.S. Food and Drug Administration (FDA); have not been prescribed for a medically necessary indication or are Experimental and/or Investigational as defined in the *Key Terms and Definitions* section.
- Non-prescribed, non-Legend and over the counter (OTC) drugs or medicines (except as preventive care medications required by the Affordable Care Act).
- Foods and nutritional supplements including (but not limited to) home meals, formulas, foods, diets, vitamins, herbs, and minerals (regardless of whether they can be purchased OTC or whether they require a prescription), except when provided during hospitalization; prenatal vitamins or minerals requiring a prescription;
- Special Food Product (as defined in the *Key Terms and Definitions* section), except for the benefit described as covered under Special Food Product in the *Schedule of Medical Benefits* section or elsewhere in this document under the section titled *Obesity Care Management Program*;
- Naturopathic, Naprapathy, or homeopathic treatments/substances.
- Weight control or anorexiants, except those anorexiants used for treatment of children with attention deficit hyperactivity disorder (ADHD) or individuals with narcolepsy or

where otherwise noted in this document under the section titled *Obesity Care Management Program*;

- Compounded Prescriptions in which there is not at least one ingredient that is a Legend Drug requiring a Prescription, as defined by federal or state law.
- Take-home drugs or medicines provided by a hospital, emergency room, ambulatory surgical facility/center, or other health care facility.
- Vaccinations, immunizations, inoculations, or preventive injections that are not covered under the Summary of Medical Benefits section.
- Marijuana and any derivative, including CBD, THC, edibles, etc. are not a covered benefit under this Plan.
- Non-prescription devices and drugs purchased from retail or mail-order pharmacies are not payable under the prescription drug program.
- Drugs to enhance athletic performance such as anabolic steroids (including off-labeled growth hormone). Coverage for human growth hormone or equivalent is excluded unless specifically covered and described in the *Summary of Medical Benefits*.
- Non-prescription male contraceptives, e.g., condoms.
- Dental products such as topical fluoride preparations and products for periodontal disease , except as a preventive service required under the Affordable Care Act.
- Hair removal or hair growth products (*i.e., Propecia, Rogaine, Minoxidil, Eflornithine, etc.*).
- Vitamin A derivatives (retinoids) for dermatologic use.
- Vitamin B-12 injections (except for pernicious anemia, other specified megaloblastic anemias not elsewhere classified, anemias due to disorders of glutathione metabolism, post-surgery care or other b-complex deficiencies), antihemophilic factors including tissue plasminogen activator (TPA), acne preparations, and laxatives (unless otherwise specified in the Schedule of Medical Benefits.
- Anti-aging treatments (even if FDA-Approved for other clinical indications)

Durable Medical Equipment:
See the exclusions related to Corrective Appliance, Orthotic Device Expenses, and Appliances.

Educational Services: Expenses for educational/vocational services, supplies or equipment including (but not limited to) computers, software, printers, books, tutoring, visual aids, auditory aides, and speech aides, programs to assist with auditory perception or listening/learning skills, programs/services to remedy or enhance concentration, memory, motivation, or self-esteem, etc. (even if they are required because of an injury, illness, or disability of a covered individual).

Electronic cigarettes: The Plan does not cover electronic cigarettes.

Employer-Provided Services: Expenses for services rendered through a medical department, clinic or similar facility provided or maintained by you or your covered dependents' employer; or for benefits otherwise provided under this Plan or any other plan that PEBP contributes to or otherwise sponsors (e.g., HMOs).

Expenses Exceeding Maximum Plan Benefits: Expenses that exceed any Plan benefit limitation or Plan Year maximum benefits as described in this document.

Expenses Exceeding Usual and Customary Charges, the Plan's Maximum Allowable Charge, Prevailing Rates and PPO Contracted Rates: Any portion of the expenses for covered medical services or supplies that are determined by the Plan Administrator or its designee to exceed the Plan's Maximum Allowable Charge, Usual and Customary Charge, prevailing rates or PPO contracted rate as defined in the *Key Terms and Definitions* section, except as required by independent dispute resolution under the No Surprises Act.

Expenses for Which a Third-Party Is Responsible: See "Third-Party Liability" of the Health and Welfare Wrap document that can be found on www.pebp.state.nv.us (NAC 287.755)**.**

Expenses Incurred Before or After Coverage: Expenses for services rendered or supplies provided either before the patient became covered under the Plan or after the date the patient's coverage ends, except under those conditions described in COBRA Continuation Coverage.

Experimental and/or Investigational Services: Unless mandated by law, expenses for any medical services, supplies, drugs, or medicines that are determined by the Plan Administrator, UM company or its designee to be experimental and/or investigational services.

Fertility and Infertility Treatment:
Except as otherwise specified in the Schedule of Medical Benefits section, all other costs incurred for reproduction by artificial means or assisted reproductive technology (such as in-vitro fertilization, or embryo transplants) are excluded. This exclusion includes treatments, testing, services, supplies, devices, or drugs intended to produce a pregnancy; the promotion of fertility including, but not limited to, fertility testing (except as otherwise covered and described above); serial ultrasounds; services to reverse voluntary surgically-induced infertility; reversal of surgical sterilization; any service, supply, or drug used in conjunction with or for the purpose of an artificially induced pregnancy, test-tube fertilization; the cost of donor sperm or eggs; in-vitro fertilization and embryo transfer or any artificial reproduction technology or the freezing of sperm or eggs or storage costs for frozen sperm, eggs, or embryos; including, but not limited to, determining, evaluating, or enhancing the physical or psychological readiness for pregnancy, procedures to improve the participant's ability to become pregnant or to carry a pregnancy to term; and any payment made by or on behalf of a participant who is contemplating or has entered into a contract for surrogacy to a provider or individual related to any services potentially included in the scope of surrogacy services; sperm donor for profit or prescription (infertility) drugs; or GIFT or ZIFT procedures, low tubal transfers, or donor egg retrieval are also excluded.

Foot/Hand Care:
Expenses for non-symptomatic foot care such as the removal of warts (except plantar warts); corns or calluses; and including but not limited to podiatry treatment of bunions, toenails, flat feet, fallen arches, and chronic foot strain; and expenses for routine foot care (including but not limited to: trimming of toenails, removal of corns and callouses, preventive care with assessment

of pulses, skin condition and sensation) or hand care, (including manicure and skin conditioning), unless the Plan Administrator or its designee determines such care to be medically necessary.

Routine foot care from a podiatrist for treatment of foot problems such as corns, calluses and toenails are payable for individuals with a metabolic disorder such as diabetes, or a neurological or peripheral-vascular insufficiency affecting the feet.

Gender Dysphoria and/or Gender Services: Certain procedures associated with gender dysphoria treatment and/or gender related surgery found to be non-medically necessary in the Treatment for Gender Dysphoria section above are not covered.

- No more than one genital surgery in the individual's lifetime covered under any current or previous PEBP health plan.
- There is no coverage for travel costs.
- A surgery to reverse a surgery to treat gender dysphoria will not be covered.

Genetic Testing and Counseling: Coverage is not available for tests solely for research, or for the benefit of individuals not covered under this Plan.

Expenses for genetic testing and counseling are excluded, unless otherwise specified in this Plan's Schedule of Medical Benefits.

Growth Hormone: Coverage for off-labeled growth hormone.

Gym Fees: Fees by personal trainers or gym or health club memberships, exercise programs, or exercise physiologists, even if recommended by a professional to treat a medical condition.

Hair: Expenses for or related to hair removal, hair transplants and other procedures to replace lost hair or to promote the growth of hair, including prescription and non-prescription drugs such as Minoxidil, Propecia, Rogaine, Eflornithine; or for hair replacement devices, including (but not limited to) wigs, toupees and/or hairpieces or hair analysis. Patients undergoing chemotherapy may be able to receive benefits for some hair replacement devices, as listed above.

Hearing Care: Special education and associated costs in conjunction with sign language education for a patient or family members.

Hearing Aids: Over the Counter hearing aids are excluded from the Plan.

Home Birth/Delivery: Planned birth/delivery at home and associated services are not covered by this Plan. Guidelines for Perinatal Care published by the American Academy of Pediatrics and American College of Obstetricians and Gynecologists (ACOG) that the hospital, including a birthing center within the hospital complex, or a freestanding birthing center, provides the safest setting for labor, delivery, and the postpartum period. The use of other settings is not covered

by this Plan. Facilities providing obstetrical care should have the services listed as essential components of a Level 1 hospital.

Home Health Care:

- Expenses for any home health care services that are not medically necessary, other than part-time, intermittent skilled nursing services and supplies.
-
- Expenses for a homemaker, custodial care, childcare, adult care, or personal care attendant, except as provided under the Plan's hospice coverage.
- Expenses for any home health care services that is not provided by an organization or professional licensed by the state to render home health services.
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- Over-the-counter medical equipment supplies or any prescription drugs, except otherwise provided in the Summary of Medical Benefits and Schedule of Medical Benefits.

Expenses for any services provided substantially or primarily for the participant's convenience or the convenience of a caregiver.

Hospital Employee, Medical Students, Interns or Residents: Expenses for the services of an employee of a hospital, skilled nursing facility or other health care facility, when the facility is obligated to pay that employee.

Illegal Act: Expenses incurred by a covered individual for injuries resulting from commission (or attempted commission by the covered individual) of an illegal act as determined by the plan administrator which involved violence or threat of violence to another person, or in which any weapon or explosive is used by the covered individual, unless such injury is the result of a physical or mental health condition or domestic violence. The Plan Administrator's determination that this exclusion applies shall not be affected by any prosecution, or acquittal of (or failure to prosecute) the covered individual in connection with the acts involved, unless such injury is the result of a physical or mental health condition or domestic violence.

Internet/Virtual Office Visit: Expenses related to an online internet consultation with an out-of-network physician or other health care practitioner (also called a virtual office visit/consultation), physician-patient web service or physician-patient e-mail service (including receipt of advice, treatment plan, prescription drugs or medical supplies obtained) from an online internet provider who is not a participating provider in the Plan network except as specifically provided.

Maternity/Family Planning:

- Contraception: Expenses related to prescription or non-prescription male contraceptive drugs and devices such as condoms.

- Termination of Pregnancy: Expenses for elective termination of pregnancy (abortion) unless the attending physician certifies the health of the mother would be endangered if the fetus were carried to term , and complications of such termination.
- Childbirth courses.
- Expenses related to delivery associated with a pregnant dependent child, except for expenses related to complications of pregnancy.
- Expenses related to cryo-storage of umbilical cord blood or other tissue or organs.
- For nondurable supplies.
- Reversal of prior sterilization procedures, including, but not limited to tubal ligation and vasectomy reversals.

Medically Unnecessary Services: Services or supplies determined by the Plan Administrator or its designee not to be medically necessary, as defined in the *Key Terms and Definitions* section.

Modifications of Homes or Vehicles: Expenses for construction or modification to a home, residence or vehicle required because of an injury, illness, or disability of a covered individual, including, without limitation, any construction or modification (e.g., ramps, elevators, chair lifts, swimming pools, spas, air conditioning, asbestos removal, air filtration, handrails, emergency alert system, etc.).

No-Cost Services: Expenses for services rendered or supplies provided without cost, or for which there would be no charge if the person receiving the treatment were not covered under this Plan.

No Provider Recommendation or Order: Expenses for services rendered or supplies provided that are not recommended or prescribed by a physician or other licensed provider acting within the scope of their license.,

Non-Emergency Hospital Admission: Care and treatment billed by a hospital for a non-medical emergency admission on a Friday or Saturday unless surgery is performed within 24 hours of the admission.

Non-Emergency Travel and Related Expenses: Expenses for and related to non-emergency travel or transportation (including lodging, meals, and related expenses) of a health care provider, participant except where otherwise specified in the Utilization Management section for organ/ tissue transplants and bariatric weight loss surgery or certain surgeries performed in a surgery center, inpatient hospital or outpatient setting as determined by the Plan Administrator or the UM company.

Occupational Illness, Injury or Conditions Subject to Workers' Compensation: All expenses incurred by you or any of your covered dependents arising out of or during employment if the injury, illness, or condition is subject to coverage, in whole or in part, under any workers' compensation, or occupational disease (or similar) law.

Orthodontia: Expenses for any services relating to orthodontia evaluation and treatment even if the orthodontia services are provided as the result of an injury or illness.

Personal Comfort Items: Expenses for patient convenience, including (but not limited to) care of family members while the covered individual is confined to a hospital (or other health care facility, or to bed at home), guest meals, television, VCR/DVD, telephone, barber or beautician services, house cleaning or maintenance, shopping, birth announcements, photographs of new babies, etc.

Private Room in a Hospital or Health Care Facility: The use of a private room in a hospital or other health care facility, unless the facility has only private room accommodations, or unless the use of a private room is certified as medically necessary by the Plan Administrator or its designee.

Prophylactic Surgery or Treatment: Unless otherwise noted in this document, expenses for medical or surgical services or procedures, including prescription drugs and the use of prophylactic surgery, as defined in the *Key Terms and Definitions* section of this document, when the services, procedures, prescription of drugs, or prophylactic surgery is prescribed or performed for:

- Avoiding the possibility or risk of an illness, disease, physical or mental disorder or condition based on family history and/or genetic test results, in certain circumstances; or
- Treating the consequences of chromosomal abnormalities or genetically transmitted characteristics when there is an absence of objective medical evidence of the presence of disease or physical or mental disorder. Participants should use the Plan's UM company to assist in the determination of a proposed surgery to determine if it is or is not covered under this Plan.

NOTE: Some prophylactic surgeries may be covered under this Plan if certain criteria are met. Please refer to the *Schedule of Medical Benefits* section. For additional information, please contact this Plan's UM company or Claims Administrator.

Prophylactic drugs are excluded.

Rehabilitation Therapy (Inpatient or Outpatient):

- Expenses for educational, job training, vocational rehabilitation, and/or special education for sign language.
- Expenses for massage therapy, Rolfing, and related services.
- Expenses incurred at an inpatient rehabilitation facility for any inpatient rehabilitation therapy services provided to an individual who is unconscious, comatose, or in the

judgment of the Plan Administrator or its designee, is otherwise incapable of conscious participation in the therapy services and/or unable to learn and/or remember what is taught, including (but not limited to) coma stimulation programs and services.

- Expenses for maintenance rehabilitation, as defined in the *Key Terms and Definitions* section.
- Expenses for speech therapy for functional purposes including (but not limited to) stuttering, stammering and conditions of psychoneurotic origin.
- Expenses for cognitive therapy are excluded unless related to short-term services necessitated by a catastrophic neurological event to restore functioning for activities of daily living.
- Therapies, psychological services, counseling, or tutoring services for developmental delay or learning disability.
- Treatment that a federal or state law mandates that coverage be provided and paid for by a school district or other governmental agency.

Service Animals: Purchase, training, or maintenance of any type of service animal, even if designated as medically necessary.

Smoking/Tobacco Cessation: Expenses for non-prescription (over the counter) tobacco/smoking cessation products such as nicotine gum or patches, unless prescribed by a physician. There are no benefits payable for the use of electronic cigarettes. Prescription smoking/tobacco cessation products are payable under the prescription drug benefit as described in the *Schedule of Medical Benefits* section.

Stand-By Physicians or Health Care Practitioners: Expenses for any physician or other provider who did not directly provide or supervise medical services to the patient, even if the physician or practitioner was available on a stand-by basis.

Telephone Calls: Expenses for all telephone calls between a physician or other health care provider and any patient, other health care provider, UM company or vendor; or any representative of this Plan for any purpose whatsoever.

Transplant (Organ and Tissue) Experimental and/or Investigational:
Human organ and/or tissue transplants that are experimental and/or Investigational, including (but not limited to) donor screening, acquisition and selection, organ or tissue removal, transportation, transplants, post-operative services and drugs or medicines, and all complications thereof.

Non-human (Engrafted) organ and/or tissue transplants or implants, except heart valves.

- Expenses incurred by the person who donates the organ or tissue, unless the person who receives the donated organ/tissue is the person covered by this Plan

Travel Outside of the United States: Any services received outside the United States are excluded unless deemed to be urgent or emergency care.

Vision Care:
Charges for the fitting and cost of visual aids, vision therapy, eye therapy, orthoptics with eye exercise therapies, refractive errors including but not limited to eye exams and surgery done in treating myopia (except for corneal graft); ophthalmological services provided in connection with the testing of visual acuity for the fitting for eyeglasses or contact lenses, eyeglasses or contact lenses (except coverage for the first pair of eyeglasses or contact lenses following cataract surgery); and surgical correction of near or far vision inefficiencies such as laser and radial keratotomy are excluded, except as otherwise specified in this Plan's *Summary of Medical Benefits and Schedule of Medical Benefits*.

War or Similar Event: Expenses incurred because of an injury or illness due to you or your covered dependent(s)' participation in any act of war, either declared or undeclared, war-like act, riot, insurrection, rebellion, or invasion, except as required by law.

Weight Management and Physical Fitness:
- Medical or surgical treatment for weight-related disorders including (but not limited to) surgical interventions, dietary programs, and prescription drugs, except those services specified in the *Summary of Medical Benefits* and *Schedule of Medical Benefits.* Surgery for weight reduction must be performed at a Bariatric Center of Excellence. Expenses for weight loss surgery performed without a precertification from the UM company will be denied.
- Expenses related to programs such as Weight Watchers, Jenny Craig, Nutri-Systems, Slim Fast or the rental or purchase of any form of exercise equipment.
- Expenses for medical or surgical treatment of severe underweight, including (but not limited to) high calorie and/or high protein food supplements or other food or nutritional supplements, except in conjunction with medically necessary treatment of anorexia, bulimia, or acute starvation. Severe underweight means a weight more than 25 percent under normal body weight for the patient's age, sex, height, and body frame based on weight tables generally used by physicians to determine normal body weight.
- Expenses for memberships in or visits to health clubs, exercise programs, gymnasiums, and/or any other facility for physical fitness programs, including exercise equipment.
- One obesity related surgery per lifetime while covered under any PEBP self-funded medical Plan (e.g., LD PPO Plan, CDHP and Exclusive Provider Organization Plan).

Other Benefit Exclusions
- Stress reduction therapy or cognitive behavior therapy for sleep disorders.
- Sleep therapy (except for central or obstructive apnea when medically necessary and when a precertification has been received from the UM company), behavioral training or therapy, milieu therapy, biofeedback (unless included with psychotherapy), behavior modification,

sensitivity training, hypnosis, electro hypnosis, electro-sleep therapy, electro-narcosis, massage therapy, and gene therapy.

- Charges that result from appetite control, food addictions, or any treatment of obesity, unless otherwise provided in the *Summary of Medical Benefits* and *Schedule of Medical Benefits.*
- Except as otherwise provided in the *Summary of Medical Benefits* and *Schedule of Medical Benefits*, drugs, medicines, procedures, services, and supplies to correct or enhance erectile function, enhance sensitivity or for sexual dysfunction (organic or inorganic), inadequacy, or enhancement, including penile implants and prosthetics, injections, and durable medical equipment.
- Aroma therapy, massage therapy, reiki therapy, thermograph, orthomolecular therapy, contact reflex analysis, Bio-Energetic Synchronization Technique (BEST), colonic irrigation, magnetic innervation therapy and electromagnetic therapy.
- Natural and herbal remedies that may be purchased without a prescription (over the counter), through a web site, at a Physician or Chiropractor's office, or at a retail location are excluded, unless otherwise specified in the *Summary of Medical Benefits and Schedule of Medical Benefits.*

Medical Claims Administration

How Medical Benefits are Paid

Plan benefits are considered for payment on the receipt of written proof of claim, commonly called a bill. Generally, health care providers send their bill to PEBP's third-party claims administrator directly. Plan benefits for eligible services performed by health care providers will then be paid directly to the provider delivering the services. When Deductibles, Coinsurance or copayments apply, you are responsible for paying your share of these charges.

If services are provided through the PPO network, the PPO health care provider may submit the proof of claim directly to PEBP's third-party claims administrator; however, you will be responsible for the payment to the PPO health care provider for any applicable Deductible, Coinsurance, or copayments.

If a health care provider does not submit a claim directly to PEBP's third-party claims administrator and instead sends the bill to you, you should follow the steps outlined in this section regarding How to File a Claim. If, at the time you submit your claim, you furnish evidence acceptable to the Plan administrator or its designee (PEBP's third-party claims administrator) that you or your covered dependent paid some or all those charges, Plan benefits may be paid to you, but only up to the amount allowed by the Plan for those services after Plan Year Deductible and Coinsurance amounts are met.

How to File a Medical Claim

All claims must be submitted to the Plan within 12 months from the date of service. No Plan benefits will be paid for any claim submitted after this period. Benefits are based on the Plan's provisions in place on the date of service.

See also, NAC 287.610.

Most providers send their bills directly to the PEBP's claims administrator; however, for providers who do not bill the Plan directly, you may be sent a bill. In that case, follow these steps:

- Obtain a claim form from PEBP's third-party claims administrator or PEBP's website (see the *Participant Contact Guide* in this document for details on address, phone, and website).
- Complete the participant part of the claim form in full. Answer every question, even if the answer is "none" or "not applicable (N/A)."
- The instructions on the claim form will tell you what documents or medical information is necessary to support the claim. Your physician, health care practitioner or dentist can complete the health care provider part of the claim form, or you can attach the itemized bill for professional services if it contains all the following information:

- A description of the services or supplies provided including appropriate procedure codes.
- Details of the charges for those services or supplies.
- Appropriate diagnosis code.
- Date(s) the services or supplies were provided.
- Patient's name.
- Provider's name, address, phone number, and professional degree or license.
- Provider's federal tax identification number (TIN).
- Provider's signature.

Please review your bills to be sure they are appropriate and correct. Report any discrepancies in billing to the Claims Administrator. This can reduce costs to you and the Plan. Complete a separate claim form for each person for whom Plan benefits are being requested. If another plan is the primary payer, send a copy of the other plan's Explanation of Benefits (EOB) along with the claim you submit to this Plan.

To assure that medical, pharmacy or dental expenses you incur are eligible under this Plan, the Plan has the right to request additional information from any hospital, facility, physician, laboratory, radiologist, dentist, pharmacy or any other eligible medical or dental provider. For example, the Plan has the right to deny Deductible and Out-of-Pocket Maximum credit or payment to a provider if the provider's bill does not include or is missing one or more of the following components. This is not an all-inclusive list:

- Itemized bill to include but not be limited to: Proper billing codes such as CPT, HCPCS, Revenue Codes, CDT, ICD 9, and ICD 10.
- Date(s) of service.
- Place of service.
- Provider's Tax Identification Number.
- Provider's signature.
- Operative report.
- Patient ledger.
- Emergency room notes.
- Providers such as hospitals and facilities that bill for single or bulk items such as orthopedic devices/implants or other types of biomaterials shall provide to the third-party claim's administrator a copy of the manufacturer's/organization's invoice (that directly supplied the device/implant/biomaterial to the healthcare provider). This Plan will deny payment for such medical devices until a copy of the invoice is provided to this Plan's Claims Administrator.

Claims are processed by the third-party claims administrator in the order they are received.

It is your responsibility to maintain copies of the EOB documents provided to you by PEBP's third-party claims administrator or prescription drug administrator. Copies of EOB documents are available on the Claims Administrator's website but cannot be reproduced. PEBP and its third-

party claims administrator do not provide printed copies of EOB documents outside of the original mailing.

Where to Send the Claim Form

Send the completed claim form, the bill you received (retain a copy for your records) and any other required information to the Claims Administrator at the address listed in the *Participant Contact Guide* in this document.

Appeals

You have the right to ask PEBP or its designees to reconsider a claim or Utilization Management Adverse Benefit Determination resulting in a denial, reduction, termination, failure to provide or make payments (in whole or in part) for a service or treatment, Rescission of coverage (retroactive cancellation), or HRA claim.

Discretionary Authority of PEBP and Designee

In carrying out their respective responsibilities under the Plan, PEBP and its designees have discretionary authority to interpret the terms of the Plan and to determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination made under that discretionary authority would be given full force and effect unless it can be shown that the interpretation or determination was arbitrary and capricious. Services that are covered, as well as specific Plan exclusions are described in this document.

Medical and Dental Claims and HRA Appeals

Written Notice of Adverse Benefit Determination

The Plan or its designee, the third-party administrator, will notify you in writing on an Explanation of Benefits (EOB) of an Adverse Claim Determination resulting in a denial, reduction, termination, or failure to provide or make payments (in whole or in part) of a benefit. The notice will explain the reasons why, with reference to the Plan provisions as to the basis for the adverse determination and it will explain what steps to take to submit a Level 1 Claim Appeal. When applicable, the notice will explain what additional information is required from you and why it is needed. A participant or their designee cannot circumvent the claims and appeals procedures by initiating a cause of action against the PEBP (or the State of Nevada) in a court proceeding.

You will be provided with:

(a) upon request and without charge, reasonable access to and copies of all relevant documents, records and other information relevant to your claim for benefits;

(b) the opportunity to submit written comments, documents, records and other information relating to the claim for benefits;

(c) a full and fair review that takes into account all comments, documents, records and other information submitted by you, without regard to whether such information was submitted or considered in the initial benefit determination;

(d) automatically and free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the denied claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date.

Additionally, before the Plan issues an Adverse Benefit Determination on review based on a new or additional rationale, you will be provided, automatically and free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you reasonable time to respond prior to that date.

If the Plan receives new or additional evidence or rationale so late in the claim filing or claim appeal process that a claimant would not have a reasonable opportunity to respond, the period for providing a final determination is delayed until such time as the claimant has had such an opportunity.

Level 1 Claim Appeal

NAC 287.670

If your claim is denied, or if you disagree with the amount paid on a claim, you may request a Level 1 Claim Appeal from the third-party administrator within 180 days of the date you received the Explanation of Benefits (EOB) which provides the claim determination. Failure to request a Level 1 Claim Appeal in a timely manner will be deemed to be a waiver of any further right of review of appeal under the Plan, unless good cause can be demonstrated. The written request for appeal must include:

- The name and Social Security Number, or identification number of the participant.
- A copy of the EOB related to the claim being appealed; and
- A detailed written explanation why the claim is being appealed.

You have the right to review documents applicable to the denial and to submit your own comments in writing. The third-party administrator will review your claim (by a person at a higher level of management than the one who originally denied the claim). If any additional information is needed to process your request for appeal, it will be requested promptly.

The third-party administrator will issue a decision of your Level 1 Claim Appeal in writing within 20 days after receipt of your request for appeal.

You will receive a notice of the appeal determination. If that determination is adverse, it will include at each level of the appeal review, the following:

(a) information that is sufficient to identify the claim involved (e.g. date of service, health care provider, claim amount if applicable);
(b) the statement that, upon request and free of charge, the diagnosis code and/or treatment code, and their corresponding meanings, will be provided. However, a request for this information will not be treated as a request for a 2nd level of appeal or external review (when external review is applicable);
(c) the specific reason(s) for the adverse appeal review decision, including the denial code and its corresponding meaning and a discussion of the decision, as well as any Plan standards used in denying the claim;
(d) reference the specific Plan provision(s) on which the determination is based;

(e) a statement that you are entitled to receive upon request, free access to and copies of documents relevant to your claim;
(f) an explanation of the Plan's appeal process and Level 2 appeal process and the external review process (when external review is applicable), along with any time limits and information regarding how to initiate the next level of review, as well as a statement of the voluntary Plan appeal procedures, if any;
(g) if the denial was based on an internal rule, guideline, protocol or similar criterion, a statement will be provided that such rule, guideline, protocol or criteria that was relied upon will be provided free of charge to you, upon request;
(h) if the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request;
(i) the statement that "You and your Plan may have other voluntary dispute resolution options such as mediation. One way to find out what may be available is to contact your local U. S. Department of Labor Office and your State insurance regulatory agency;" and

(j) disclosure of the availability of, and contact information for, any applicable health insurance consumer assistance or ombudsman established under the Public Health Services Act to assist individuals with internal claims and appeals and external review processes (when external review is applicable).

The notification will explain the steps necessary if you wish to proceed to a Level 2 Appeal if you are not satisfied with the response at Level 1.

Level 2 Claim Appeal

NAC 287.680

If you are unsatisfied with the Level 1 Claim Appeal decision made by the third-party administrator, you may file a Level 2 Claim Appeal to the PEBP Executive Officer or designee by completing a Claim Appeal Request form. *Claim Appeal Request form*s are available at www.pebp.state.nv.us or by request by contacting PEBP Customer Service at 775-684-7000 or 800-326-5496. A Level 2 Appeal must be submitted to PEBP within 35 days after you receive the Level 1 Appeal determination. Your Level 2 Appeal **must** include a copy of:

- Any document submitted with your Level 1 Appeal request.
- A copy of the Level 1 Appeal decision; and
- Any documentation to support your request.

The Executive Officer or designee will use all resources available to assure a thorough review is completed in accordance with provisions of the Plan.

A Level 2 Appeal decision will be given to you in writing by certified mail within 30 days after the Level 2 Appeal request is received by the Executive Officer or designee. A Level 2 Appeal determination will explain and reference the reasons for the decision, including the applicable provisions of the Plan upon which the determination is based.

External Claim Review

NAC 287.690

Standard Request

An External Claim Review may be requested by a participant and/or the participant's treating physician after exhausting the Level 1 and Level 2 Claim Appeals process. This means that you may have a right to have the Plan's or its designee's decision reviewed by independent health care professionals if the adverse benefit determination involved making a judgment as to the medical necessity, appropriateness, health care setting, level of care or effectiveness of the health care setting or treatment you requested.

An External Claim Review request must be submitted in writing to the Office for Consumer Health Assistance (OCHA) within four (4) months after the date of receipt of a notice of the Level 2 Claim Appeal decision. An *External Review Request Form* is available on the PEBP website at www.pebp.state.nv.us. The OCHA will assign an independent external review organization within five 5 days after receiving the request. The external review organization will issue a determination within 15 days after it receives the complete information. For standard Request for External Claim Review, a decision will be made within 45 days of receiving the request.

A Request for External Claim Review must include:

- completed and signed External Review Request Form.
- a copy of the EOB(s) related to the claim(s) being reviewed.
- a detailed written explanation why the external review is being requested; and
- any additional supporting documentation.

The Request for External Claim Review must be submitted to:

Office for Consumer Health Assistance
3320 W. Sahara Avenue, Suite 100
Las Vegas NV 89102
Phone: (702) 486-3587,
(888) 333-1597
Fax 702-486-3586
Web: *http://dhhs.nv.gov/Programs/CHA/*

Appealing a Utilization Management Determination

The utilization management (UM) company is staffed with licensed health care professionals, who utilize nationally recognized health care screening criteria along with the medical judgment of their licensed health care professional, operating under a contract with the Plan to administer utilization review services. The review includes a process to determine the medical necessity, appropriateness, location, and cost effectiveness of health care services. Depending on the service, a review may occur before, during, or after the services are rendered, including, but not limited to precertification/pre-authorization; concurrent and/or continued stay review; discharge planning; retrospective review; and case management.

Pursuant to applicable NRS 695G, you have the following appeal processes for any adverse benefit determination made during the precertification, concurrent review, retrospective review, or case management. An appeal may be initiated by the participant, treating provider, parent, legal guardian, or person authorized to make health care decisions by a power of attorney.

The UM company will utilize a physician (other than the physician who rendered the original decision) to review the appeal. This physician is Board Certified in the area under review and is in active practice. Refer to the *Participant Contact Guide* for the UM company's contact information.

Internal UM Appeal Review

Expedited Internal UM Appeal Review

You may request an expedited appeal review of a denied precertification of a hospital admission, availability of care, continued stay or health care service for which you received emergency services but have not been discharged from the facility providing the care; or if the physician certifies that failure to proceed in an expedited manner may jeopardize your life or health or the life or health of your covered dependent or the ability for you or your covered dependent to regain maximum function.

Requests for an expedited internal UM appeal review may be made by telephone or any other reasonable means to the UM company that will ensure the timely receipt of the information required to complete the appeal process. If your physician requests a consultation with the reviewing physician, this will occur within one business day. The UM company will decide on an expedited appeal within 72 hours of receipt of the information needed to complete the appeal. The results of the determination of an expedited appeal will be provided immediately to the managing physician by phone and in writing to the patient, managing physician, facility, and the third-party claim's administrator.

If the appeal review request is denied, the UM company will provide the member with an adverse benefit determination letter including the clinical rationale for the non-certification decision and the member may pursue an external appeal as described in NRS 695G.241 - NRS 695G.275.

Standard Internal UM Appeal Review

If you have a denied precertification request (or a denial/non-certification at any other level of UM review such as concurrent review, retrospective review, or case management issue) and you do not qualify for an expedited appeal, you may request a standard appeal review. Requests for standard appeal review may be made by writing to the UM company.

Requests for standard appeal review must be made within 180 days of the date of the denial/non-certification. Actual medical records are encouraged to be provided to assist the reviewer. Standard appeals for pre-service denials will be reviewed by a physician within 15 days of the UM company's receipt of the request. Appeals for post-service treatment will be completed within 20 days of the receipt of the request. The results of the determination of a standard appeal will

be provided in writing to the patient, managing physician, facility, and third-party claim's administrator.

A participant or their designee can choose to bypass the internal appeals process from adverse benefit determinations resulting from the UM company and request a review by an external review organization.

External UM Appeal Review

An external review may be requested by a participant and/or the participant's treating physician after you have exhausted the internal UM appeal review process. This means you may have the right to have the Plan Administrator or its designee's decision reviewed by independent health care professionals if the adverse benefit determination involved making a judgement as to the medical necessity, appropriateness, health care setting, level of care or effectiveness of the health care setting or treatment you requested.

Expedited Request for External Review (Pre-Service Urgent UM Appeal)

NRS 287.04335

For adverse benefit determinations resulting from the UM company, a participant or their designee can choose to bypass the internal UM appeal process and request a review by an external review organization.

Expedited external review is available only if the request is filed within four (4) months after the date of receipt of a notice of an adverse benefit determination and the patient's treating provider certifies that adherence to the time frame for the standard external review would seriously jeopardize the life or health of the covered individual or would jeopardize the covered individual's ability to regain maximum function. Pursuant to NRS 695G.271, the Office for Consumer Health Assistance (OCHA) will approve or deny a request for an external review of an adverse determination not later than 72 hours after receipt from the provider. If OCHA determines the request qualifies for expedited review, a final of the external review will made by the external review organization within 72 hours of receipt and the provider and participant will be notified within 24 hours.

A participant may file a request for an expedited external review with the Office for Consumer Health Assistance (OCHA) if the request is filed within four (4) months after the date of receipt of a notice of an adverse benefit determination or final internal adverse benefit determination. An expedited external review request form, which includes a certification of treating provider for expedited consideration can be found on the PEBP website at www.pebp.state.nv.us.

The request must be submitted to:

Office for Consumer Health Assistance
3320 W. Sahara Avenue, Suite 100
Las Vegas NV 89102
Phone: (702) 486-3587,

(888) 333-1597
Fax 702-486-3586
Web: *http://dhhs.nv.gov/Programs/CHA/*

Standard Request for External UM Review

A standard request for external UM review may be filed with the Office for Consumer Health Assistance (OCHA) if the request is filed within four (4) months after the date of receipt of a notice of an adverse benefit determination or final internal adverse benefit determination. A standard external review request form can be found on the PEBP website at www.pebp.state.nv.us.

A standard external review decision will be made within 45 days of OCHA's receipt of the request.

As with the expedited external review, a standard external review must be submitted to the Office for Consumer Health Assistance at the contact information listed above.

Experimental and/or Investigational Claim/UM External Review

If you received a denial for a service, durable medical equipment, procedure, or other therapy because the third-party administrator or the UM company determined it to be experimental and/or investigational, or subject to the No Surprises Act, or rescission of coverage, you may request an external review. To proceed with the experimental and/or investigational external review, you must obtain a certification from the treating physician indicating that the treatment would be significantly less effective if not received.

A "Physician Certification of Experimental/Investigational /Denials" is located under "Forms" on the PEBP website at www.pebp.state.nv.us.

After this form is completed by the treating physician, it should be attached to the Request for External Review" form and submitted to the Office for Consumer Health Assistance at:

Office for Consumer Health Assistance
3320 W. Sahara Avenue, Suite 100
Las Vegas NV 89102
Phone: (702) 486-3587,
(888) 333-1597
Fax 702-486-3586
Web: *http://dhhs.nv.gov/Programs/CHA/*

Prescription Drug Review and Appeals

A participant has the right to request that a medication be covered or be covered at a higher benefit (e.g., lower copay, higher quantity, etc.). The first request for coverage is called an initial coverage review. The Pharmacy Benefit Manager reviews both clinical and administrative coverage review requests, including those cases related to specialty drugs dispensed through Accredo specialty pharmacy.

Clinical Coverage Review

The initial clinical coverage review is a request for coverage or medication that is based on clinical conditions of coverage that are set by this Plan—for example, medications that require a prior authorization. To make an initial determination for a clinical coverage review request, the prescribing physician must submit specific information for review.

How to Request a Clinical Coverage Review

The preferred method to request an initial clinical review is for the prescribing physician to submit the prior authorization request electronically. Alternately, the participant's prescribing physician or pharmacist may call Express Scripts at *1-800-753-2851 or the prescriber may submit a request in writing using a Benefit Coverage Review Form, which can be obtained by calling Express Scripts Member Services at 1-855-889-7708.* ~~1-855-889-7708 or the prescriber may submit a completed Initial Coverage Review form obtained online at www.express-scripts.com/services/physicians/~~. (Home delivery coverage review requests are automatically initiated by the home delivery pharmacy as part of filling the prescription.)

Administrative Coverage Review

The initial administrative coverage review is a request for coverage of a medication that is based on the Plan's benefit design.

How to Request an Administrative Coverage Review

To request an initial administrative coverage review, the participant must submit the request in writing to Express Scripts to the attention of the Benefit Coverage Review Department (see *Participant Contact Guide* section).

For an administrative coverage review request, the participant must submit information to the pharmacy benefits manager to support the request.

If the patient's situation meets the definition of urgent under the law, an urgent review may be requested and conducted as soon as possible, but no later than 72 hours from receipt of request. In general, an urgent situation is one which, in the opinion of the attending provider, the patient's health may be in serious jeopardy, or the patient may experience pain that cannot be adequately controlled while the patient waits for a decision on the review. If the patient or provider believes the patient's situation is urgent, the expedited review must be requested by calling Express Scripts at 1-800-753-2851.

If the necessary information is provided to Express Scripts so that a determination can be made, the initial determination and notification for a clinical coverage or administrative coverage review will be made within the timeframe below:

- Standard Pre-Service: 15 days for retail pharmacy and five (5) days for home delivery; and
- Standard Post-Service: 30 days.

Level 1 Appeal or Urgent Appeal

When an initial administrative or clinical coverage review request has been denied, a request for appeal of the denial may be submitted by the participant within 180 days from receipt of notice of the initial adverse benefit determination. To initiate an appeal, the following information must be submitted by mail or fax to Express Scripts' Benefit Coverage Review Department:

- Name of patient.
- Participant ID number.
- Phone number.
- The drug name for which benefit coverage has been denied.
- Brief description of why the claimant disagrees with the initial adverse benefit determination; and
- Any additional information that may be relevant to the appeal, including physician/prescriber statements/letters, bills, or any other documents.

An urgent appeal may be submitted if in the opinion of the attending provider, the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function or would subject the patient to sever pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Urgent appeals must be submitted by phone at 1-800-753-2851 or fax 1-877-852-4070 to Express Scripts. Appeals submitted by mail will not be considered urgent processing unless a subsequent phone call or fax identifies the appeal as urgent.

Express Scripts completes appeals per business policies that are aligned with state and federal regulations. Depending on the type of appeal, appeal decisions are by Express Scripts' pharmacist, physician, panel of clinicians, trained prior authorization staff member, or an independent third-party prescription drug utilization management company.

<u>Level 1 Appeal Decisions and Notifications</u>

Express Scripts will render Level 1 Appeal determinations within the following timeframes:

- Standard pre-service: 15 days.
- Standard post-service: 20 days; and
- Urgent*: 72 hours.

If new information is received and considered or relied upon in the review of the appeal, such information will be provided to the patient and prescriber together with an opportunity to respond prior to issuance of any final adverse benefit determination. Standard Post-Service: NAC 287.670

Level 2 Appeal

When a Level 1 Appeal has been denied, a request for a Level 2 Appeal may be submitted by the participant within 35 days from receipt of notice of the Level 1 Appeal denial. To initiate a Level

2 Appeal, you must request by mail or fax to the appropriate Clinical Coverage or Administrative Coverage Review Request department.

An urgent Level 2 Appeal may be submitted if in the opinion of the attending provider, the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function or would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Urgent appeals must be submitted by phone or fax to the appropriate Clinical Coverage or Administrative Coverage Review Request department (see the *Participant Contact Guide* section). Claims and appeals submitted by mail will not be considered for urgent processing unless a subsequent phone call or fax identifies the appeal as urgent.

Level 2 Appeal Decisions and Notifications

Express Scripts will render Level 2 Appeal determinations within the following timeframes:

- Standard pre-service: 15 days.
- Standard post-service: 30 days; and
- Urgent*: 72 hours.

If new information is received and considered or relied upon in the review of the appeal, such information will be provided to the patient and prescriber together with an opportunity to respond prior to issuance of any final adverse determination. Standard Post-Service: NAC 287.680

External Reviews

The right to request an independent external review may be available for an adverse benefit determination involving medical judgement, rescission, or a decision based on medical information, including determinations involving treatment that is considered experimental and investigation. Generally, all internal appeal rights must be exhausted prior to requesting an external review. The external review will be conducted by an independent review organization with medical experts that were not involved in the prior determination of the claim.

To submit an external review, the request must be mailed or faxed to the independent review organization (see *Participant Contact Guide*) within 4 (four) months of the date of the Level 2 Appeal denial. (If the date that is 4 (four) months from that date is a Saturday, Sunday, or a holiday, the deadline will be the next business day).

Standard External Review: the pharmacy benefit manager will review the external review request within 5 (five) business days to determine if it is eligible to be forwarded to an independent review organization (IRO) and the patient will be notified within 1 (one) business day of the decision.

If the request is eligible to be forwarded to an IRO, the request will randomly be assigned to an IRO, and the Appeal information will be compiled and sent to the IRO within 5 (five) business days of assigning the IRO. The IRO will notify the claimant in writing that it has received the request for an external review and if the IRO has determined that the claim involves medical judgement or rescission, the letter will describe the claimant's right to submit additional information within 10 business days for consideration to the IRO. Any additional information the claimant submits to the IRO will also be sent back to the pharmacy benefit manager for reconsideration. The IRO will review the claim within 45 calendar days from receipt of the request and will send the claimant, the Plan and the pharmacy benefit manager written notice of its decision. If the IRO has determined that the claim does not involve medical judgement or rescission, the IRO will notify the claimant in writing that the claim is ineligible for a full external review.

Urgent External Review

Once an urgent external review request is submitted, the claim will immediately be reviewed to determine if it is eligible for an urgent external review. An urgent situation is one where in the opinion of the attending provider, the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health or the ability for the patient to regarding maximum function or would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

If the claim is eligible for urgent processing, the claim will immediately be reviewed to determine if the request is eligible to be forwarded to an IRO, and the claimant will be notified of the decision. If the request is eligible to be forwarded to an IRO, the request will randomly be assigned to an IRO and the Appeal information will be compiled and sent to the IRO. The IRO will review the claim within 72 hours from receipt of the request and will send the claimant written notice of its decision.

Coordination of Benefits

For information, refer to the separate PEBP Health and Welfare Wrap Document available at www.pebp.state.nv.us under “4.4 Coordination of Benefits” (NAC 287.755).

Subrogation and Third-Party Recovery

Subrogation applies to situations where the Participant is injured, and another person or entity is or may be responsible, liable, or contractually obligated, for whatever reason, for the payment of certain damages or claims arising from or related in any way to the Participant's injury (the "Injury"). These damages or claims arising from the injury, irrespective of the way they are categorized, may include, without limitation, medical expenses, pain and suffering, loss of consortium, and/or wrongful death. The Plan has a right of subrogation irrespective of whether the damages or claims are paid or payable to the Participant, the Participant's estate, the Participant's survivors, or the Participant's attorney(s). All payments made by the Plan for which it claims a right of subrogation are referred to as subrogated payments.

The subrogation provision provides the Plan with a right of recovery for certain payments made by the Plan, irrespective of fault, or negligence wrongdoing. All payments made by the Plan relating in any way to the injury may be recovered directly from the other person or from any judgment, verdict or settlement obtained by the participant in relation to the injury.

The Participant must cooperate fully, always, and provide all information needed or requested by the Plan to recover payments, execute any papers necessary for such recovery, and do whatever is necessary or requested to secure and protect the subrogation rights of the Plan. The Participant's required cooperation includes, but is not limited to, the following actions, which must be performed immediately, upon request by the Plan:

(1) Executing an acknowledgment form or other document acknowledging and agreeing to protect the Plan's right of subrogation.
(2) Cooperating and participating in the Plan's recovery efforts, including but not limited to participating in litigation commenced or pursued by the Plan or its Board; and
(3) Filing a claim or demand with another insurance company, including but not limited to the Participant's own first party insurance policy or another person's or entity's insurance policy.

Refer to the separate *Health and Welfare Benefits Wrap Plan* document available at www.pebp.state.nv.us for more information regarding third-party liability and subrogation.

Participant Contact Guide

Participant Contact Guide	
Public Employees' Benefits Program (PEBP) **901 S. Stewart Street, Suite 1001** **Carson City, NV 89701** **Customer Service:** **(775) 684-7000, (702) 486-3100, or (800) 326-5496** **Fax: (775) 684-7028** **www.pebp.state.nv.us**	**Plan Administrator** • Enrollment and eligibility • COBRA information and premium payments • Level 2 claim appeals • External review coordination
UMR **Claims Submission** **P O Box 30541** **Salt Lake City, UT 84130-0541** **EDI #39026** **Appeal of Claims** **P O Box 30546** **Salt Lake City, UT 84130-0546** **Customer Service: (888) 763-8232** **www.UMR.com** **Diabetes Care Management form submission** **UMR** **27 Corporate Hill Drive** **Little Rock, AR 77205 Fax: 800-458-0701** **Email: diabetes@HealthscopeBenefits.com**	**Third-party Claims Administrator/Third-party Administrator/PPO Network/Disease Management Administrator for Diabetes** • Claim submission • Claim status inquiries • Level 1 claim appeals • Verification of eligibility • Plan Benefit Information • CDHP & Dental only ID Cards • Obesity Care Management Program • Disease Care Management Program • Sierra Health-Care Options (SHO) – Southern Nevada PPO Network • UnitedHealthcare Choice Plus – Outside of Southern Nevada PPO Network • Behavioral Health-Care Options (BHO) – Behavioral Health Network in Nevada
Utilization Management Company **Sierra Health-Care Options, Inc** **PO BOX 15645** **Las Vegas, NV 89144-5648** **Customer Service : 888-323-1461** **Fax : 800-282-8845**	• Pre-Certification/Prior Authorization • Utilization Management • Case Management • Transplants
Express Scripts Pharmacy Benefit Administrator **Customer Service and Prior Authorization** **(855) 889-7708**	Pharmacy Benefit Manager for Prescription Drugs information • Retail network pharmacies

www.Express-Scripts.com Accredo Patient Customer Service (800) 803-2523 Accredo Physician Service Line (800) 987-4904 option 5 Express Scripts / Accredo Prior Authorization (800) 753-2851 Electronic options: express-scripts.com/PA Specialty Medication SaveOnSP copay assistance (800) 683-1074 www.saveonsp.com/pebp ~~Express Scripts Pharmacy Benefit Administrator~~ ~~Customer Service and Prior Authorization~~ ~~(855) 889-7708~~ ~~www.Express-Scripts.com~~ ~~Express Scripts Home Delivery/Accredo Specialty Drug Services~~ ~~PO Box 66566~~ ~~St. Louis, MO 63166-6566~~ ~~Customer Service: (855) 889-7708~~ ~~Express Scripts Benefit Coverage Review Department~~ ~~PO Box 66587, St. Louis, MO 63166-6587~~ ~~Phone: 800-946-3979~~ ~~Administrative Coverage Review and Appeals~~ ~~SaveonSP~~ ~~1-800-683-1074~~	• Prior authorization • Customer service • Formulary, forms, online ordering • Price a Medication tool • Home delivery service and Mail Order forms • Preferred Mail Order for diabetic supplies **Express Scripts Clinical Appeals Department** PO Box 66588 St. Louis, MO 63166-6588 Phone: 800-753-2851 Fax: 877-852-4070 • Clinical Reviews **MCMC LLC Attn: Express Scripts Appeal Program** 300 Crown Colony Dr. Suite 203 Quincy, MA 02169-0929 Phone: 617-375-7700 ext. 28253 Fax: 617-375-7683 External Review Requests
Diversified Dental Services **5470 Kietzke Lane, Ste 300** **Reno, NV 89511** **ProviderRelations@ddsppo.com** **1-866-270-8326** **diversifieddental.com**	PPO Dental Network • Statewide PPO Dental Providers • Dental Provider directory • National PPO Dental Providers outside of Nevada utilizes the Principal Dental Network

HSA Bank HRA Claim Submission **PO Box 2744** **Fargo, ND 58108-2744** **hsaforms@hsabank.com** **Fax: 855-764-5689** **www.hsabank.com** **Customer Service:** **833-228-9364** **askus@hsabank.com** **myaccounts.hsabank.com**	• HSA and HRA Claims Administrator
United Healthcare **Group Number: 370074** **Customer Service: 1-888-763-8232** **UnitedHealthcare Specialty Benefits** **P.O. Box 7149** **Portland, ME 04112-7149**	• Basic Life Insurance for eligible active and retirees
The Standard Insurance Company **900 SW Fifth AvenuePortland, OR 97204** **(888) 288-1270** ***https://www.standard.com/mybenefits/nevada/***	• Voluntary (Supplemental) Life Insurance • Long-Term Disability • Voluntary Short-Term Disability • Generali Travel Assistance • Beneficiary Designations
Office for Consumer Health Assistance **555 E. Washington Avenue, Suite 4800** **Las Vegas, NV 89101** **Customer Service:** **(702) 486-3587 or (888) 333-1597** ***http://dhhs.nv.gov/Programs/CHA/Contact_GovCHA/***	• Consumer Health Assistance • Concerns and problems related to coverage • Provider billing issues • External review information

Key Terms and Definitions

The following terms or phrases are used throughout this MPD. These terms or phrases have the following meanings. These terms and definitions do not, and should not be interpreted to, extend coverage under the Plan.

Accident: A sudden and unforeseen event that is not work-related, resulting from an external or extrinsic source.

Active Rehabilitation: refers to therapy in which a patient, who can learn and remember, actively participates in the rehabilitation that is intended to provide significant and measurable improvement of an individual who is restricted and cannot perform normal bodily function.

Actively Engaged:

- Participation in regular office visits with your provider. The frequency of the office visits will be determined by your provider who will in turn report this information to the third-party administrator for monitoring.
- Consistently demonstrating a commitment to weight loss by adhering to the weight loss treatment plan developed by your weight loss provider including but not limited to routine exercise, proper nutrition and diet, and pharmacotherapy if prescribed. Commitment to your weight loss treatment will be measured by the third-party administrator who will review monthly progress reports submitted by the provider; and
- Losing weight at a rate determined by the weight loss provider.

Activities of Daily Living: Activities performed as part of a person's daily routine, such as getting in and out of bed, bathing, dressing, feeding, or eating, use of the toilet, ambulating, and taking drugs or medicines that can be self-administered.

Acupuncture: A technique for treating disorders of the body by passing long thin needles through the skin. This technique is based on the belief that physical illness and disorders are caused by imbalances in the life force, called Qi, which flows through the body along meridians or channels, and that the needles stimulate the natural healing energy flow.

When benefits for the services of an acupuncturist are payable by this Plan, the acupuncturist must be properly licensed by the state in which he or she is practicing and must be performing services within the scope of that license, or, where licensing is not required, be certified by the National Certification Commission for Acupuncturists (NCCA).

Adverse Benefit Determination: NRS 695G.0–2 - Means a determination by a health carrier or utilization review organization that an admission, availability of care, continued stay or other health care service that is a covered benefit has been reviewed and, based upon the information provided, does not meet the health carrier's requirements for medical necessity,

appropriateness, health care setting, level of care or effectiveness, and the requested service or payment for the service is therefore denied, reduced or terminated.

Air Ambulance: A medical transport by a rotary wing air ambulance, as defined in 42 CFR 414.605, or fixed wing air ambulance, as defined in 42 CFR 414.605, for patients.

Allogenic: Refers to transplants of organs, tissues, or cells from one person to another person. Heart Transplants are always Allogenic.

Allowable Expenses: The Maximum Allowable Charge for any medically necessary, eligible item of expense, at least a portion of which is covered under the Plan. When some other non-Medicare plan pays first in accordance with the application to benefit determinations provision in the *Coordination of Benefits* section, this Plan's allowable expenses shall in no event exceed the other non-Medicare plan's allowable expenses.

When some other non-Medicare plan provides benefits in the form of services rather than cash payments, the Plan Administrator shall assess the value of each service rendered, by determining the amount that would be payable in accordance with the terms of the Plan, shall be deemed to be the benefit. Benefits payable under any other non-Medicare plan include the benefits that would have been payable had claim been duly made; therefore, whether or not it is made.

Ambulance: A vehicle or boat that is licensed or certified for emergency patient transportation by the jurisdiction in which it operates.

Ambulatory Surgical Facility/Center: A specialized facility that is established, equipped, operated, and staffed primarily for performing surgical procedures and which fully meets one of the following two tests:

- It is licensed as an ambulatory surgical facility/center by the regulatory authority responsible for the licensing under the laws of the jurisdiction in which it is located; or

Where licensing is not required, it meets all the following requirements:

- It is operated under the supervision of a licensed physician who is devoting full time to supervision and permits a surgical procedure to be performed only by a duly qualified physician who, at the time the procedure is performed, is privileged to perform the procedure in at least one hospital in the area.
- It requires in all cases, except those requiring only local infiltration anesthetics, that a licensed anesthesiologist administer the anesthetic or supervise an anesthetist who is administering the anesthetic, and that the anesthesiologist or anesthetist remain present throughout the surgical procedure.
- It provides at least one operating room and at least one post-anesthesia recovery room.
- It is equipped to perform diagnostic x-ray and laboratory examinations or has an arrangement to obtain these services.

- It has trained personnel and necessary equipment to handle emergency situations.
- It has immediate access to a blood bank or blood supplies.
- It provides the full-time services of one or more registered graduate nurses (RNs) for patient care in the operating rooms and in the post-anesthesia recovery room; and
- It maintains an adequate medical record for each patient, which contains an admitting diagnosis (including, for all patients except those undergoing a procedure under local anesthesia, a preoperative examination report, medical history, and laboratory tests and/or x-rays), an operative report and a discharge summary.

An ambulatory surgical facility/center that is part of a hospital, as defined in this section, will be considered an ambulatory surgical facility/center for the purposes of this Plan.

Ancillary Services/Charges: Charges for services provided by a hospital or other facility other than room and board, including (but not limited to) use of the operating room, recovery room, intensive care unit, etc., and laboratory and x-ray services, drugs and medicines, and medical supplies provided during confinement.

Ancillary services, for purposes of the No Surprises Act, are, with respect to a PPO health care facility:

- Items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a physician or non-physician practitioner,
- Items and services provided by assistant surgeons, hospitalists, and intensivists;
- Diagnostic services, including radiology and laboratory services and subject to exceptions specified by the Secretary; and

Items and services provided by a Non-PPO provider if there is no PPO provider who can furnish such item or service at such facility.

Anesthesia: The condition produced by the administration of specific agents (anesthetics) to render the patient unconscious and without conscious pain response (e.g., general anesthesia), or to achieve the loss of conscious pain response and/or sensation in a specific location or area of the body (e.g., regional, or local anesthesia). Anesthetics are commonly administered by injection or inhalation.

Annual/Annually: For the purposes of this Plan, annual and annually refers to the 12-month period starting July 1 through June 30.

Appliance (Dental): A device to provide or restore function or provide a therapeutic (healing) effect.

Appropriate: See the definition of medically necessary for the definition of appropriate as it applies to medical services that are medically necessary.

Approved Clinical Trial: A phase I, II, III, or IV trial if it is conducted for the prevention, detection, or treatment of cancer or another disease or condition likely to lead to death unless the course of the disease or condition is interrupted.

An Approved Clinical Trial's study must be:

(1) approved or funded by one or more of:
- (a) the National Institutes of Health (NIH),
- (b) the Centers for Disease Control and Prevention (CDC),
- (c) the Agency for Health Care Research and Quality (AHCRQ),
- (d) the Centers for Medicare and Medicaid Services (CMS),
- (e) a cooperative group or center of the NIH, CDC, AHCRQ, CMS, the Department of Defense (DOD), or the Department of Veterans Affairs (VA),
- (f) a qualified non-governmental research entity identified by NIH guidelines for grants; or
- (g) the VA, DOD, or Department of Energy (DOE) if the study has been reviewed and approved through a system of peer review that the Secretary of HHS determines is comparable to the system used by NIH and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review;

(2) a study or trial conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA); or

(3) a drug trial that is exempt from investigational new drug application requirements.

Assistant Surgeon: A medically qualified doctor who assists the surgeon of record perform a procedure.

Autism Spectrum Disorders and related terms Have the meanings ascribed to them under NRS 695G.1645 and NRS 427A.875.

Autologous: Refers to transplants of organs, tissues, or cells from one part of the body to another. Bone marrow and skin transplants are often autologous.

Average Wholesale Price (AWP): The average price at which drugs are purchased at the wholesale level.

Bariatric Surgery Center of Excellence: This provider has met the requirements outlined by the American College of Surgeons National Surgical Quality Improvement Program (ACS NSQIP) and is accredited by the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP). The accreditation of a Bariatric Surgery Center of Excellence helps identify providers with whom a participant should expect to receive safer and more effective surgical

treatment. These MBSAQIP accredited providers adhere to a multidisciplinary surgical preparatory regimen to include but not limited to the following:

- Behavior modification program supervised by a qualified professional.
- Consultation with a dietician or nutritionist.
- Documentation in the medical record of the participant's active participation and compliance with the multidisciplinary surgical preparatory regimen at each visit. A physician's summary letter, without evidence of concurrent oversight is not sufficient documentation. Documentation should include medical records of the physician's initial assessment of the participant, and the physician's assessment of the participant at the completion of the multidisciplinary surgical preparatory regimen.
- Exercise regimen (unless contraindicated) to improve pulmonary reserve prior to surgery, supervised by an exercise Therapist or other qualified professional.
- Program must have a substantial face-to-face component (must not be entirely delivered remotely); and
- Reduced-calorie diet program supervised by dietician or nutritionist.

Base Plan: The self-funded Consumer Driven Health Plan (CDHP); the base plan is also defined as the "default plan" where applicable in this document and other materials produced by PEBP (NRS 287.045).

Behavioral Health Disorder: Any illness that is defined within the mental disorders section of the current edition of the International Classification of Diseases (ICD) manual or is identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), including a psychological and/or physiological dependence on or addiction to alcohol or psychiatric drugs or medications regardless of any underlying physical or organic cause.

Behavioral health disorders covered under this Plan may include, but are not limited to depression, schizophrenia, and substance abuse and treatment that primarily uses psychotherapy or other psychotherapist methods and is provided by behavioral health practitioners as defined in this section. Certain behavioral health disorders, conditions and diseases are specifically excluded from coverage as noted in the *Exclusions* section.

Behavioral Health Practitioner: A psychiatrist, psychologist, or a mental health or substance abuse counselor or social worker who has a master's degree, or other provider who is legally licensed and/or legally authorized to practice or provide service, care, or treatment of behavioral health disorders under the laws of the state or jurisdiction where the services are rendered; and acts within the scope of his or her license.

Behavioral Health Treatment: Services, including room and board, given by a behavioral health treatment facility or area of a hospital that provides behavioral or mental health or substance abuse treatment for a mental disorder identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM). If there are multiple diagnoses, only the treatment

for the illness that is identified under the DSM code is considered a behavioral health treatment for the purposes of this Plan.

Behavioral Health Treatment Facility: A specialized facility that is established, equipped, operated, and staffed primarily for providing a program for diagnosis, evaluation, and effective treatment of behavioral health disorders and which fully meets one of the following two tests:

- It is licensed as a behavioral health treatment facility by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located; or
- Where licensing is not required, it meets all the following requirements: has at least one physician on staff or on call and provides skilled nursing care by licensed nurses under the direction of a full-time registered nurse (RN) and prepares and maintains a written plan of treatment for each patient based on the medical, psychological, and social needs of the patient.

A behavioral health treatment facility that qualifies as a hospital is covered by this Plan as a hospital and not a behavioral health treatment facility. A transitional facility, group home, halfway house or temporary shelter is not a behavioral health treatment facility under this Plan unless it meets the requirements above in the definition of behavioral health treatment facility.

Benefit, Benefit Payment, Plan Benefit: The amount of money payable for a claim, based on the usual and customary charge, subject to the Plan's Maximum Allowable Charge, or negotiated fee schedule, after calculation of all Deductibles, Coinsurance, and copayments, and after determination of the Plan's exclusions, limitations, and maximums.

Birth (or Birthing) Center: A specialized facility that is primarily a place for delivery of children following a normal uncomplicated pregnancy and which fully meets one of the two following tests:

- It is licensed by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located; or
- Where licensing is not required, it meets all the following requirements:
- It is operated and equipped in accordance with any applicable state law for providing prenatal care, delivery, immediate post-partum care, and care of a child born at the center.
- It is equipped to perform routine diagnostic and laboratory examinations, including (but not limited) to hematocrit and urinalysis for glucose, protein, bacteria and specific gravity, and diagnostic x-rays, or has an arrangement to obtain those services.
- It has available to handle foreseeable emergencies, trained personnel, and necessary equipment, including (but not limited to) oxygen, positive pressure mask, suction, intravenous equipment, equipment for maintaining infant temperature and ventilation, and blood expanders.
- It provides at least two beds or two birthing rooms.

- It is operated under the full-time supervision of a licensed physician, registered nurse (RN) or certified nurse midwife.
- It has a written agreement with at least one hospital in the area for immediate acceptance of patients who develop complications.
- It has trained personnel and necessary equipment to handle emergency situations.
- It has immediate access to a blood bank or blood supplies.
- It has the capacity to administer local anesthetic and to perform minor surgery.
- It maintains an adequate medical record for each patient that contains prenatal history, prenatal examination, any laboratory or diagnostic tests and a post-partum summary.
- It is expected to discharge or transfer patients within 48 hours following delivery.

A birth (or birthing) center that is part of a hospital, as defined in this section, will be a birth (or birthing) center for the purposes of this Plan.

Business Day: Refers to all weekdays, except Saturday or Sunday, Nevada holiday, or federal holiday.

Case Management: A process administered by the UM company in which its medical professionals work with the patient, family, caregivers, providers, Claims Administrator, Pharmacy Benefit Manager and PEBP to coordinate a timely and cost-effective treatment program. Case management services are particularly helpful when the patient needs complex, costly, and/or high-technology services, and when assistance is needed to guide patients through a maze of potential providers.

Cardiac Rehabilitation: Cardiac Rehabilitation refers to a formal program of controlled exercise training and cardiac education under the supervision of qualified medical personnel capable of treating cardiac emergencies, as provided in a hospital outpatient department or other outpatient setting. The goal is to advance the patient to a functional level of activity and exercise without cardiovascular complications to limit further cardiac damage and reduce the risk of death. Patients are to continue at home the exercise and educational techniques they learn in this program. Cardiac rehabilitation services are payable for patients who have had a heart attack (myocardial infarction) or open-heart surgery.

Certified Surgical Assistant: A person who does not hold a valid health care license as an RN, Nurse Practitioner (NP), Physician Assistant (PA), Podiatrist, Dentist, MD or DO, who assists the primary surgeon with a surgical procedure in the operating room and who bills, commonly as an assistant surgeon , and who acts within the scope of his/her license or certification. Such individuals are payable by this Plan, including but not limited to designation as a Certified Surgical Assistant (CSA), Certified Surgical Technologist (CST), Surgical Technologist (ST), Certified Technical Assistant (CTA), or Certified Operating Room Technician (CORT).

Chemical Dependency: This is another term for Substance Abuse. (See also the definitions of Behavioral Health Disorders and Substance Abuse).

Child(ren): See the definition of Dependent Child(ren).

Chiropractor: A person who holds the degree of Doctor of Chiropractic (DC) and is legally licensed and authorized to practice the detection and correction, by mechanical means, of the interference with nerve transmissions and expressions resulting from distortion, misalignment, or dislocation of the spinal column (vertebrae); and who acts within the scope of his or her license.

Chiropractic Services: PEBP considers chiropractic services to be medically necessary when all the following criteria are met:

- participant has objective medical findings of a neuro-musculoskeletal disorder; and
- a clearly defined treatment plan has been established including treatment and discharge goals; and
- services are not for maintenance purposes.

Christian Science Practitioner: Christian Science is a system of religious teaching based on an interpretation of scripture, founded in 1866 by Mary Baker Eddy. It emphasizes full healing of disease by mental and spiritual means. Certain members of the Christian Science church are designated as Christian Science Practitioners who counsel and assist church members in mental and spiritual means to overcome illness based on Christian Science teachings.

Chronic Medication Synchronization:

"Chronic medication" means any drug that is prescribed to treat any disease or other condition which is determined to be permanent, persistent, or lasting indefinitely.

"Synchronization" means the alignment of the dispensing of multiple medications by a single contracted pharmacy for improving a patient's adherence to a prescribed course of medication. This includes providing coverage for less than a 30 day supply to enable synchronization.

Claims Administrator: The person or company retained by the Plan to administer claim payment responsibilities and other administration or accounting services as specified by the Plan.

Clinical Trials: See ***Experimental and Investigational*** in the *Key Terms and Definitions* section.

Coinsurance: That portion of *Eligible Medical Expenses* for which the covered person has financial responsibility. In most instances, the covered individual is responsible for paying a percentage of covered medical expenses more than the Plan's Deductible. The Coinsurance varies depending on whether In-Network or Out-of-Network providers are used.

Complications of Pregnancy: Any condition that requires hospital confinement for medical treatment, and if the pregnancy is not terminated, is caused by an injury or sickness not directly related to the pregnancy or by acute nephritis, nephrosis, cardiac decompensation, missed abortion or similar medically diagnosed conditions; or, any condition that requires hospital confinement and if the pregnancy is terminated, results in non-elective cesarean section, ectopic pregnancy or spontaneous termination.

Compound Drugs: Any drug that has more than one ingredient and at least one of them is a Federal Legend Drug or a drug that requires a prescription under state law.

Concierge Medicine: Is a relationship between a patient and a primary care physician or dentist in which the patient usually pays an annual or monthly fee or retainer to receive easier access to a primary care provider or dentist. Concierge medicine usually means that the patient will experience quicker scheduling of appointments, limited or no waiting times, longer and more thorough examinations and coordination of all medical or dental care. Other terms in use include boutique medicine, retainer-based medicine, and innovative medical practice design. The practice is also referred to as membership medicine, concierge health care, cash only practice, direct care, direct primary care, and direct practice medicine. Most concierge medicine practices do not bill insurance.

Concurrent Review: A managed care program designed to assure that hospitalization and health care facility admissions and length of stay, surgery and other health care services are medically necessary by having the utilization management company conduct ongoing assessment of the health care as it is being provided, especially (but not limited to) inpatient confinement in a hospital or health care facility.

Continuing Care Patient: An individual who, with respect to a provider or facility-

1. is undergoing a course of treatment for a serious and complex condition from the provider or facility;
2. is undergoing a course of institutional or inpatient care from the provider or facility;
3. is scheduled to undergo non-elective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such a surgery;
4. is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or

is or was determined to be terminally ill (as determined under section 1861(dd)(3)(A) of the Social Security Act) and is receiving treatment for such illness from such provider or facility.

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Convalescent Care Facility: See the definition of Skilled Nursing Facility.

Coordination of Benefits (COB): The rules and procedures applicable to the determination of how Plan benefits are payable when a person is covered by two or more health care plans.

Copayment, Copay: The fixed dollar amount you are responsible for paying when you incur an eligible medical expense for certain services, generally those provided by network health care practitioners, hospitals (or emergency rooms of hospitals), or health care facilities. This can be in addition to Coinsurance amounts due on the same incurred charges. Copayments are limited to certain benefits under this program.

Corrective Appliances: The general term for appliances or devices that support a weakened body part (orthotic) or replace a missing body part (prosthetic). To determine the category of any item, see also the definitions of Durable Medical Equipment, Nondurable Supplies, Orthotic Appliance (or device) and Prosthetic Appliance (or device).

Cosmetic Surgery or Treatment: Surgery or medical treatment to improve or preserve physical appearance, but not physical function. Cosmetic surgery or treatment includes medical, dental, or surgical treatment intended to restore or improve physical appearance, as determined by the Plan Administrator, UM company, or its designee.

Cost-Efficient: See the definition of medically necessary for the definition of cost-efficient as it applies to medical services that are medically necessary.

Cost sharing: The amount a participant or beneficiary is responsible for paying for a covered item or service under the terms of the plan. Cost sharing generally includes copayments, coinsurance, and amounts paid towards deductibles, but does not include amounts paid towards premiums, balance billing by Non-PPO providers, or the cost of items or services that are not covered under the plan.

Cost Sharing Amount for Emergency and Non-emergency Services at PPO Facilities performed by Non-PPO Providers, and air ambulance services from Non-PPO providers will be based on the Recognized Amount.

Covered Individual: Any employee or retiree (as those terms are defined in this Plan), and that person's eligible spouse or dependent child who has completed all required formalities for enrollment for coverage under the Plan and is covered by the Plan.

Covered Medical Expenses: See the definition of *Eligible Medical Expenses*.

Custodial Care: Care and services given mainly for personal hygiene or to perform the activities of daily living. Some examples of custodial care are helping patients get in and out of bed, bathe, dress, eat, use the toilet, walk (ambulate), or take drugs or medicines that can be self-administered. These services are custodial care regardless of where the care is given or who recommends, provides, or directs the care. Custodial care can be given safely and adequately (in

terms of generally accepted medical standards) by people who are not trained or licensed medical or nursing personnel. Custodial care may be payable by this Plan under certain circumstances, such as when custodial care is provided during a covered hospitalization or during a covered period of hospice care.

Customary Charge: See the definition of Usual and Customary Charge.

Deductible: The amount of eligible medical, prescription drug and dental expenses you are responsible for paying before the Plan begins to pay benefits. The dental Deductibles are discussed in the separate PPO Dental Master Plan Document.

Dental: As used in this document, dental refers to any services performed by (or under the supervision of) a dentist, or supplies (including dental prosthetics). Dental services include treatment to alter, correct, fix, improve, remove, replace, reposition, restore or treat teeth; the gums and tissues around the teeth; the parts of the upper or lower jaws that contain the teeth (the alveolar processes and ridges); the jaw, any jaw implant, or the joint of the jaw (the Temporomandibular Joint); bite alignment, or the meeting of upper or lower teeth, or the chewing muscles; and/or teeth, gums, jaw or chewing muscles because of pain, injury, decay, malformation, disease or infection. Dental services and supplies coverage is provided in the PPO Dental Plan (refer to the separate PPO Dental Plan MPD available at www.pebp.state.nv.us) and are not covered under the medical expense coverage of this Plan unless the medical Plan specifically indicates otherwise in the *Schedule of Medical Benefits*.

Dependent: Any of the following individuals: Dependent child(ren), spouse or domestic partner as those terms are defined in this document.

Dependent Child(ren): See also (NAC 287.312). For the purposes of this Plan, a dependent child is any of your children under the age of 26 years, including:

- natural child,
- child(ren) of a domestic partner,
- stepchild,
- legally adopted child or child placed in anticipation for adoption (the term placed for adoption means the assumption and retention by the employee of a legal obligation for total or partial support of the child in anticipation of adoption of the child and the child must be available for adoption and the legal adoption process must have commenced),
- child who qualifies for benefits under a QMCSO/NMSN (see the *Eligibility* section for details on QMCSO/NMSN),
- any other person who:
  (1) Bears a relationship described in 26 U.S.C. § 152(c)(2) to the participant or his or her spouse or domestic partner.
  (2) Is unmarried.

Disability: A determination by the Plan Administrator or its designee (after evaluation by a physician) that a person has a permanent or continuing physical or mental impairment causing the person to be unable to be self-sufficient as the result of having the physical or mental impairment such as intellectual disability, cerebral palsy, epilepsy, neurological disorder, or psychosis.

Domestic Partner: As defined by NRS 122A.030.

Drug: See the definition for prescription drug.

Durable Medical Equipment: Equipment that can withstand repeated use; and is primarily and customarily used for a medical purpose and is not generally useful in the absence of an injury or illness; and is not disposable or non-durable and is appropriate for the patient's home. Durable medical equipment includes (but is not limited to) apnea monitors, augmentation devices, blood sugar monitors, commodes, electric hospital beds with safety rails, electric and manual wheelchairs, nebulizers, oximeters, oxygen and supplies, and ventilators.

Elective Hospital Admission, Service or Procedure: Any non-emergency hospital admission, service or procedure that can be scheduled or performed at the patient's or physician's convenience without jeopardizing the patient's life or causing serious impairment of body function.

Eligible Medical Expenses: Expenses for medical services or supplies, but only to the extent that they are medically necessary; and the charges for them are usual and customary and do not exceed the Plan's Maximum Allowable Charge or negotiated fee schedule; and coverage for the services or supplies is not excluded (as provided in the *Exclusions* section); and the Plan Year maximum benefits for those services or supplies has not been reached.

Emergency: See the definition for Medical Emergency.

Emergency Medical Condition: A medical condition, including mental health condition or substance use disorder, manifested by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in serious impairment to bodily functions, serious dysfunction of any bodily organ or part, or placing the health of a woman or her unborn child in serious jeopardy.

- **Emergency Care:** Medical and health services provided for an Emergency Medical Condition as defined above.

This Plan does not require precertification for medically necessary emergency services provided at any hospital in accordance with NRS 695G.170. For information, refer to the separate PEBP Health and Welfare Wrap Document available at www.pebp.state.nv.us.

Emergency Services means the following:

5. An appropriate medical screening examination that is within the capability of the emergency department of a hospital or of an independent freestanding emergency department, as applicable, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and
6. Within the capabilities of the staff and facilities available at the hospital or the independent freestanding emergency department, as applicable, such further medical examination and treatment as are required to stabilize the patient (regardless of the department of the hospital in which such further examination or treatment is furnished).

Emergency Services furnished by a Non-PPO provider or Non-PPO emergency facility (regardless of the department of the hospital in which such items or services are furnished) also include post stabilization services (services after the patient is stabilized) and as part of outpatient observation or an inpatient or outpatient stay related to the emergency medical condition, until:

- The provider or facility determines that the participant or beneficiary is able to travel using nonmedical transportation or nonemergency medical transportation; or
- The participant or beneficiary is supplied with a written notice, as required by federal law, that the provider is a Non-PPO provider with respect to the Plan, of the estimated charges for your treatment and any advance limitations that the Plan may put on your treatment, of the names of any PPO providers at the facility who are able to treat you, and that you may elect to be referred to one of the PPO providers listed; and
- The participant or beneficiary gives informed consent to continued treatment by the Non-PPO provider, acknowledging that the participant or beneficiary understands that continued treatment by the Non-PPO provider may result in greater cost to the participant or beneficiary.

Emergency Surgery: A surgical procedure performed within 24 hours of the sudden and unexpected severe symptom of an illness, or within 24 hours of an accidental injury causing a life-threatening situation.

Employee: Unless specifically indicated otherwise when used in this document, employee refers to a person employed by an agency or entity that participates in the PEBP program, and who is eligible to enroll for coverage under this Plan.

Employer: Unless specifically indicated otherwise when used in this document, employer refers to an agency or entity that participates in the PEBP program, including (but not limited to) most State agencies, as well as some county and city agencies and organizations.

Enteral Formulas: Enteral Formulas is subject to NRS 689B.0353.

Exclusions: Specific conditions, circumstances, and limitations, as set forth in the *Exclusions* section for which the Plan does not provide Plan benefits.

Experimental and/or Investigational Services: NRS 695G.173 Required provision concerning coverage for treatment received as part of clinical trial or study.

Unless mandated by law, the Plan Administrator or its designee has the discretion and authority to determine if a service or supply is, or should be, classified as experimental and/or investigational. A service or supply will be deemed to be experimental and/or investigational if, in the opinion of the Plan Administrator or its designee, based on the information and resources available at the time the service was performed or the supply was provided, or the service or supply was considered for precertification under the Plan's utilization management program, any of the following conditions were present with respect to one or more essential provisions of the service or supply:

- The service or supply is described as an alternative to more conventional therapies in the protocols (the plan for the course of medical treatment that is under investigation) or consent document (the consent form signed by or on behalf of the patient) of the health care provider that performs the service or prescribes the supply.
- The prescribed service or supply may be given only with the approval of an Institutional Review Board as defined by federal law.
- In the opinion of the Plan Administrator or its designee, there is either an absence of authoritative medical, dental or scientific literature on the subject, or a preponderance of such literature published in the United States, and written by experts in the field, that shows that recognized medical, dental or scientific experts: classify the service or supply as experimental and/or investigational; or indicate that more research is required before the service or supply could be classified as equally or more effective than conventional therapies.
- With respect to services or supplies regulated by the Food and Drug Administration (FDA), FDA approval is required for the service and supply to be lawfully marketed; and it has not been granted at the time the service or supply is prescribed or provided; or a current Investigational new drug or new device application has been submitted and filed with the FDA. However, a drug will not be considered experimental and/or investigational if it is:
    - Approved by the FDA as an "Investigational new drug for treatment use"; or
    - Classified by the National Cancer Institute as a Group C cancer drug when used for treatment of a "life threatening disease," as that term is defined in FDA regulations; or
    - Approved by the FDA for the treatment of cancer and has been prescribed for the treatment of a type of cancer for which the drug was not approved for general use, and the FDA has not determined that such drug should not be prescribed for a given type of cancer.
    - The prescribed service or supply is available to the covered person only through participation in Phase I or Phase II clinical trials; **or** Phase III Experimental or research clinical trials or corresponding trials sponsored by the FDA, the National Cancer Institute, or the National Institutes of Health.

In determining if a service or supply is or should be classified as experimental and/or Investigational, the Plan Administrator or its designee will rely only on the following specific information and resources that are available at the time the service or supply was performed, provided, or considered for precertification under the Plan's utilization management program:

- Medical records of the covered person.
- The consent document signed, or required to be signed, to receive the prescribed service or supply.
- Protocols of the health care provider that renders the prescribed service or prescribes or dispenses the supply.
- Authoritative peer-reviewed medical or scientific writings that are published in the United States regarding the prescribed service or supply for the treatment of the covered person's diagnosis, including (but not limited to) "United States Pharmacopoeia Dispensing Information"; and "American Hospital Formulary Service".
- The published opinions of the American Medical Association (AMA), such as "The AMA Drug Evaluations" and "The Diagnostic and Therapeutic Technology Assessment (DATTA) Program, etc.; or specialty organizations recognized by the AMA; or the National Institutes of Health (NIH); or the Center for Disease Control (CDC); or the Office of Technology Assessment; or the American Dental Association (ADA), with respect to dental services or supplies.
- Federal laws or final regulations that are issued by or applied to the FDA or Department of Health and Human Services regarding the prescribed service or supply.
- The latest edition of "The Medicare Coverage Issues Manual."
- Nevada Statutes mandate the following criteria be met in cases of Cancer and Chronic Fatigue Syndrome:
    1. A policy of health insurance must provide coverage for medical treatment in a clinical study or trial if:
        a. Treatment is for either Phase I, II, III, IV cancer or Phase II, III, IV Chronic Fatigue Syndrome.
        b. Study is approved by:
            i. Agency of National Institute of Health.
            ii. A cooperative group (see bill for exact definition).
            iii. FDA for new investigational drug
            iv. US Dept. of Veteran Affairs.
            v. US Dept. of Defense.
        c. Health care provider and facility have authority to provide the care for Phase I cancer.
        d. Health care provider and facility have experience to provide the care for Phase II, III, IV cancer or chronic fatigue syndrome.
        e. No other treatment considered a more appropriate alternative.

f. Reasonable expectation based on clinical data that treatment will be at least as effective as other treatments.
g. Study is conducted in Nevada.
h. Participant signs a statement of consent that he has been informed of:
i. The procedure to be undertaken.
ii. Alternative methods of treatment.
iii. Associated risks of treatment.

2. Coverage for medical treatment is limited to:
a. A drug or device approved for sale by the FDA.
b. Reasonably necessary required services provided in treatment or as a result of complications to the extent that they would have otherwise been covered for Phase II, III, IV cancer or chronic fatigue syndrome.
c. The cost of any routine health care services that otherwise would have been covered for an insured for Phase I cancer.
d. Initial consultation; and
e. Clinically appropriate monitoring.
3. Treatment not required to be covered if provided free by sponsor.
4. Coverage does not include:
a. Portions customarily paid by other government or industry entities.
b. A drug or device paid for by manufacturer or distributor.
c. Excluded health care services.
d. Services customarily provided free in study.
e. Extraneous expenses related to study.
f. Expenses for persons accompanying participant in study.
g. Any item or service provided for data collection not directly related to study.
h. Expenses for research management of study.

NOTE: To determine how to obtain a precertification of any procedure that might be deemed to be experimental and/or investigational, see the *precertification* in the *Utilization Management* section.

Explanation of Benefits (EOB): When a claim is processed by the claims administrator you will be sent a form called an Explanation of Benefits, or EOB. The EOB describes how the claim was processed, such as allowed amounts, amounts applied to your Deductible, if your out-of-pocket maximum has been reached, if certain services were denied and why, amounts you need to pay to the provider, etc.

Extended Care Facility: See the definition of Skilled Nursing Facility.

Expedited Appeal: If a participant appeals a decision regarding a denied request for precertification (pre-service claim) for an urgent care claim, the participant or participant's authorized representative can request an expedited appeal, either orally or in writing. Decisions

regarding an expedited appeal are generally made within seventy-two (72) hours from the Plan's receipt of the request.

External Review: An independent review of an adverse benefit determination conducted by an external review organization.

External Review Organization: An organization that

1) conducts an external review of a final adverse benefit determination; and
2) is certified in accordance with regulations adopted by the Nevada Commissioner of Insurance.

Federal Legend Drugs: Any medicinal substance that the Federal Food, Drug and Cosmetic Act requires to be labeled, "Caution — Federal Law prohibits dispensing without prescription."

Food and Drug Administration (FDA): The U.S. government agency responsible for administration of the Food, Drug and Cosmetic Act and whose approval is required for certain prescription drugs and other medical services and supplies to be lawfully marketed.

Free-Standing Laboratory Facility: Free-standing laboratory facilities are stand-along facilities that are not affiliated with a hospital system. Examples of preferred free-standing laboratory facilities include Labor Corp or Quest.

Formulary: A list of generic and brand name drug products available for use by participants. This is maintained by the Pharmacy Benefit Manager and may be subject to change according to the Pharmacy Benefit Manager.

Gender Dysphoria: Gender Dysphoria, as defined by the American Psychiatric Association, refers to psychological distress that results from an incongruence between one's sex assigned at birth and one's gender identity. Generally, it is a condition in which the person has the desire to live as a member of the opposite sex and progressively take steps to live in the opposite sex role full-time.

Generic; Generic Drug: A prescription drug that has the equivalency of the brand name drug with the same use and metabolic disintegration. This Plan will consider as a generic drug any FDA approved generic pharmaceutical dispensed according to the professional standards of a licensed Pharmacist and clearly designated by the pharmacist as being generic. (See also the Prescription Drug section of the *Schedule of Medical Benefits* and the *Prescription Drug* subsection of the *Medical Exclusion* section).

Genetic Counseling: Counseling services provided before or in the absence of genetic testing to educate the patient about issues related to chromosomal abnormalities or genetically transmitted characteristics and/or the possible impacts of the results of genetic testing; and provided after Genetic Testing to explain to the patient and his or her family the significance of any detected chromosomal abnormalities or genetically transmitted characteristics that indicate

either the presence of or predisposition to a disease or disorder of the individual tested, or the presence of or predisposition to a disease or disorder in a fetus of a pregnant woman.

Genetic Information: Information regarding the presence or absence of chromosomal abnormalities or genetically transmitted characteristics in a person that is obtained from genetic testing, or that may be inferred from a person's family medical history.

Genetic Testing: Tests that involve the extraction of DNA from an individual's cells and analysis of that DNA to detect the presence or absence of chromosomal abnormalities or genetically transmitted characteristics that indicate the presence of a disease or disorder, the individual's predisposition to a disease or disorder, or the probability that the chromosomal abnormality or characteristic will be transmitted to that person's child, who will then either have that disease or disorder, a predisposition to develop that disease or disorder, or become a carrier of that abnormality or characteristic with the ability to transmit it to future generations. Tests that assist the health care practitioner in determining the appropriate course of action or treatment for a medical condition.

Gestational Carrier: Gestational carrier means an adult woman who is not an intended parent and who enters into a gestational agreement to bear a child conceived using the gametes of other persons and not her own. NRS 126.580

Government-Provided Services (Tricare/CHAMPUS, VA, etc.): Expenses for health care services provided to a covered participant that federal, state, or local law (e.g., Tricare/Champus, VA, except the Medicaid program), expenses for care required by a public entity and care for which there would not normally be a charge.

Health Care Facility: (for non-emergency services) is each of the following:

1. A hospital (as defined in section 1861(e) of the Social Security Act);
2. A hospital outpatient department;
3. A critical access hospital (as defined in section 1861(mm)(1) of the Social Security Act); and
4. An ambulatory surgical center described in section 1833(i)(1)(A) of the Social Security Act

Health Care Practitioner: A physician, behavioral health practitioner, chiropractor, dentist, nurse, nurse practitioner, physician assistant, podiatrist, or occupational, physical, respiratory or speech therapist or speech pathologist, master's prepared audiologist, optometrist, optician for vision Plan benefits, oriental medicine doctor for acupuncture or Christian Science Practitioner, or other provider who is legally licensed and/or legally authorized to practice or provide certain health care services under the laws of the state or jurisdiction where the services are rendered: and acts within the scope of his or her license and/or scope of practice.

Health Care Provider: A health care practitioner as defined above, or a hospital, ambulatory surgical facility, behavioral health treatment facility, birthing center, home health care agency, hospice, skilled nursing facility, or sub-acute care facility (as those terms are defined in this *Key Terms and Definitions* section).

Health Reimbursement Arrangement (HRA): A Health Reimbursement Arrangement (HRA) is an employer-funded spending account that can be used to pay qualified medical expenses. The HRA is 100% funded by the employer. The terms of these arrangements can provide first dollar medical coverage until the funds are exhausted or insurance coverage kicks in. The contribution amount per employee is set by the employer, and the employer determines what the funds can be used to cover and if the dollars can be rolled over to the next year. In most cases, if the employee leaves the employer, they cannot take remaining HRA funds with them.

Health Savings Account (HSA): An account that allows individuals to pay for current health expenses and save for future qualified medical and Retiree health expenses on a tax-free basis.

HIPAA: Health Insurance Portability and Accountability Act of 1996. Federal regulation affecting portability of coverage; electronic transmission of claims and other health information; privacy and confidentiality protections of health information.

HIPAA Special Enrollment: Enrollment rights under HIPAA for certain employees and dependents who experience a loss of other coverage and when there is an adoption, placement for adoption, birth, or marriage.

Home Health Care: Intermittent skilled nursing care services provided by a licensed home health care agency (as those terms are defined in this section).

Home Health Care Agency: An agency or organization that provides a program of Home Health Care and meets one of the following three tests:

- It is approved by Medicare; or
- It is licensed as a home health care agency by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located; or
- If licensing is not required, it meets all the following requirements:
- It has the primary purpose of providing a home health care delivery system bringing supportive skilled nursing and other therapeutic services under the supervision of a physician or registered nurse to the home.
- It has a full-time administrator.
- It is run according to rules established by a group of professional health care providers including physicians and registered nurses.
- It maintains written clinical records of services provided to all patients.
- Its staff includes at least one registered nurse, or it has nursing care by a registered nurse available.
- Its employees are bonded.
- It maintains malpractice insurance coverage.

Homeopathy: A school of medicine based on the theory that when large doses of drugs or substances produce symptoms of an illness in healthy people, administration of very small doses of those drugs or substances will cure the same symptoms. Homeopathy principles are designed

to enhance the body's natural protective mechanisms based on a theory that "like cures like" or "treatment by similar." See also the *Exclusions* section of this document regarding homeopathic treatment and services. When the services of homeopaths are payable by this Plan (e.g., an office visit), the homeopath must be properly licensed to practice homeopathy in the state in which he or she is practicing and must be performing services within the scope of that license or, where licensing is not required, have successfully graduated with a diploma of Doctor of Medicine in Homeopathy from an institution which is approved by the American Institute of Homeopathy and completed at least 90 hours of formal post- graduate courses or training in a program approved by the American Institute of Homeopathy.

Hospice: An agency or organization that administers a program of palliative and supportive health care services providing physical, psychological, social, and spiritual care for terminally ill persons assessed to have a limited life expectancy. Hospice care is intended to let the terminally ill spend their last days with their families at home (home hospice services) or in a home-like setting (inpatient hospice), with emphasis on keeping the patient as comfortable and free from pain as possible and providing emotional support to the patient and his or her family.

A hospice agency must meet one of the following tests:

- It is approved by Medicare; or is licensed as a hospice agency by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located; or
- If licensing is not required, it meets all the following requirements:
    a. It provides 24 hour-a-day, 7 day-a-week service.
    b. It is under the direct supervision of a duly qualified physician.
    c. It has a full-time administrator.
    d. It has a nurse coordinator who is a registered nurse with four years of full-time clinical experience. Two of these years must involve caring for terminally ill patients.
    e. The main purpose of the agency is to provide hospice services.
    f. It maintains written records of services provided to the patient.
    g. It maintains malpractice insurance coverage.
    h. A hospice agency that is part of a hospital will be considered a hospice agency for the purposes of this Plan.

Hospital: A public or private facility or institution, other than one owned by the U.S Government, licensed and operating according to law, that:

- Is legally operated in the jurisdiction where it is located.
- Is engaged mainly in providing inpatient medical care and treatment for injury and illness in return for compensation.
- Has organized facilities for diagnosis and major surgery on its premises.
- Is supervised by a staff of at least two physicians.
- Has 24-hour-a-day nursing service by registered nurses; and

- Is not a facility specializing in dentistry; or an institution which is mainly a rest home; a home for the aged; a place for drug addicts; a place for alcoholics; a convalescent home; a nursing home; an extended care or skilled nursing facility or similar institution; or a Long-Term Acute Care Facility (LTAC).

A hospital may include facilities for behavioral health treatment that are licensed and operated according to law. Any portion of a hospital used as an ambulatory surgical facility, birth (or birthing) center, hospice, skilled nursing facility, sub-acute care facility, or other place for rest, custodial care, or the aged shall not be regarded as a hospital for any purpose related to this Plan.

Illness: Any bodily sickness or disease, including any congenital abnormality of a newborn child, as diagnosed by a physician, and as compared to the person's previous condition. Pregnancy of a covered employee or covered spouse will be an illness only for coverage under this Plan. However, infertility is not an illness for coverage under this Plan.

Independent Freestanding Emergency Department: A health-care facility (not limited to those described in the definition of health care facility) that is geographically separate and distinct from a hospital under applicable State law and provides Emergency Services.

Inherited Metabolic Disorder: A genetically acquired disorder of metabolism involving the inability to properly metabolize amino acids, carbohydrates, or fats, as diagnosed by a physician using standard blood, urine, spinal fluid, tissue, or enzyme analysis. Inherited Metabolic Disorders are also referred to as inborn errors of metabolism and include Phenylketonuria (PKU), Maple Syrup Urine Disease, Homocystinuria and Galactosemia. Lactose intolerance without a diagnosis of Galactosemia is not an Inherited Metabolic Disorder under this Plan. See Special Food Products.

Injury: Any damage to a body part resulting from trauma from an external source.

Injury to Teeth): An injury to the teeth caused by trauma from an external source. This does not include an injury to the teeth caused by any intrinsic force, such as the force of biting or chewing. Benefits for injury to sound and natural teeth are payable under the medical Plan .

In-Network Provider: Means an In-Network provider that the network or one of its rental networks have contracted with or have arrangements with to provide health services to covered individuals. An In-Network provider has agreed to charge participants a discounted rate. To determine if a provider is an In-Network provider log on to www.pebp.state.nv.us. You may also call the number of the back of your ID card and a customer service representative can help you locate an In-Network provider.

In-Network Services: Services provided by a health care provider that is a member of the Plan's Preferred Provider Organization (PPO), as distinguished from Out-of-Network services that are provided by a health care provider that is not a member of the PPO network.

In-Network Contracted Rate: The negotiated amount determined by the PPO network to be the maximum amount charged by the PPO provider for a covered service. In some cases, the In-Network contracted amount may be applied to Out-of-Network provider charges.

Inpatient Services: Services provided in a hospital or other health care facility during the period when charges are made for room and board.

Intensive Care Unit: A section, ward, or wing within the hospital which:

- Is separated from other hospital facilities.
- Is operated exclusively for providing professional care and treatment for critically ill patients.
- Has special supplies and equipment necessary for such care and treatment available on a standby basis for immediate use.
- Provides room and board; and
- Provides constant observation and care by registered nurses or other specially trained hospital personnel.

Intensive Outpatient Program: An intensive outpatient program (IOP) is a kind of treatment service and support program used primarily to treat eating disorders, depression, self-harm, and chemical dependency that does not rely on detoxification. IOP operates on a small scale and does not require the intensive residential or partial day services typically offered by the larger, more comprehensive treatment facilities.

Maintenance Care: Services and supplies provided primarily to maintain, support and/or preserve a level of physical or mental function rather than to improve such function.

Maintenance Rehabilitation refers to therapy in which a patient actively participates, that is provided after a patient has met the functional goals of active rehabilitation so that no continued significant and measurable improvement is reasonably and medically anticipated, but where additional therapy of a less intense nature and decreased frequency may reasonably be prescribed to maintain, support, and or preserve the patient's functional level. Maintenance rehabilitation is not covered by the Plan.

Managed Care: Procedures designed to help control health care costs by avoiding unnecessary services or services that are costlier than others that can achieve the same result.

Maximum Amount; Maximum Allowable Charge: The benefit payable for a specific coverage item or benefit under the Plan. Maximum allowable charge(s) shall be calculated by the Plan Administrator considering and after having analyzed:

- The reasonable and appropriate amount.
- The terms of the Plan:
- Plan negotiated and contractual rates with provider(s).
- The actual billed charges for the covered services; and

- Unusual circumstances or complications requiring additional time, skill, and experience in connection with a service or supply, industry standards and practices as they relate to similar scenarios, and the cause of injury or illness necessitating the service(s) and/or charge(s).
- Medicare Allowable

The Plan will reimburse the actual charge(s) if they are less than the Plan's Maximum Allowable Charge amount(s). The Plan has the discretionary authority to decide if a charge is reasonable and appropriate, as well as medically necessary. The Maximum Allowable Charge will not include any identifiable billing mistakes including, but not limited to, up-coding, duplicate charges, and charges for services not performed.

Medically Necessary: A medical or dental service or supply will be determined to be "medically necessary" by the Plan Administrator or its designee if it:

- Is provided by or under the direction of a physician or other duly licensed health care practitioner who is authorized to provide or prescribe it (or dentist if a dental service or supply is involved); and
- Is determined by the Plan Administrator or its designee to be necessary in terms of generally accepted American Medical and Dental standards; and
- Is determined by the Plan Administrator or its designee to meet all the following requirements:
- It is consistent with the symptoms or diagnosis and treatment of the illness or injury; and
- It is not provided solely for the convenience of the patient, physician, dentist, hospital, health care provider, or health care facility; and
- It is an appropriate service or supply given the patient's circumstances and condition; and
- It is a cost-efficient supply or level of service that can be safely provided to the patient; and
- It is safe and effective for the illness or injury for which it is used.

A medical or dental service or supply will be appropriate if:

- It is a diagnostic procedure that is called for by the health status of the patient and is: as likely to result in information that could affect the course of treatment as; and no more likely to produce a negative outcome than any alternative service or supply, both with respect to the illness or injury involved and the patient's overall health condition.
- It is care or treatment that is likely to produce a significant positive outcome; and no more likely to produce a negative outcome than any alternative service or supply, both with respect to the illness or injury involved and the patient's overall health condition.
- A medical or dental service or supply will be cost-efficient if it is no costlier than any alternative appropriate service or supply when considered in relation to all health care expenses incurred in connection with the service or supply. The fact that your physician or dentist may provide, order, recommend or approve a service or supply does not mean that

the service or supply will be medically necessary for the medical or dental coverage provided by the Plan. A hospitalization or confinement to a health care facility will not be medically necessary if the patient's illness or injury could safely and appropriately be diagnosed or treated while not confined. A medical or dental service or supply that can safely and appropriately be furnished in a physician's or dentist's office or other less costly facility will not be medically necessary if it is furnished in a hospital or health care facility or other costlier facility:

- The non-availability of a bed in another health care facility, or the non-availability of a Health Care Practitioner to provide medical services will not result in a determination that continued confinement in a hospital or other health care facility is medically necessary.
- A medical or dental service or supply will not be considered medically necessary if it does not require the technical skills of a dental or health care practitioner or if it is furnished mainly for the personal comfort or convenience of the patient, the patient's family, any person who cares for the patient, any dental or health care practitioner, hospital, or health care facility.

Medically Necessary for External Review: Means health care services or products that a prudent physician would provide to a patient to prevent, diagnose or treat an illness, injury or disease or any symptoms thereof that are necessary and provided in accordance with generally accepted standards of medical practice, is clinically appropriate with regard to type, frequency, extent, location and duration, is not primarily provided for the convenience of the patient, physician or other provider of healthcare, is required to improve a specific health condition of a member or to preserve his existing state of health and the most clinically appropriate level of healthcare that may be safely provided to the participant.

Medicare: The Health Insurance for the Aged and Disabled provisions in Title XVIII of the U.S. Social Security Act as it is now amended and as it may be amended in the future.

Medicare Part A: Hospital insurance provided by the federal government that helps cover inpatient care in hospitals, skilled nursing facility, hospice, and home health care.

Medicare Part B: Medical insurance provided by the federal government that helps pay for medically necessary services like doctors' services, outpatient care, durable medical equipment, home health services, and other medical services.

Medicare Part D: Prescription drug coverage subsidized by the federal government but is offered only by private companies contracted with Medicare such as HMOs and PPOs.

Medi-Span: A national drug pricing information database for drug pricing analysis and comparison.

Mental Disorder; Mental and Nervous Disorder: See the definition of Behavioral Health Disorder.

Midwife, Nurse Midwife: A person legally licensed as a Midwife or certified as a Certified Nurse Midwife in the area of managing the care of mothers and babies throughout the maternity cycle, as well as providing general gynecological care, including history taking, performing physical examinations, ordering laboratory tests and x-ray procedures, managing labor, delivery and the post-delivery period, administer intravenous fluids and certain medications, provide emergency measures while awaiting aid, perform newborn evaluation, sign birth certificates, and bill and be paid in his or her own name, and who acts within the scope of his or her license. A Midwife may not independently manage moderate or high-risk mothers, admit to a hospital, or prescribe all types of medications. See also the definition of Nurse.

Morbid Obesity: Characterized by body mass index >40 kg/m(2) as defined by the National Library of Medicine.

Naturopathy: A therapeutic system based on principles of treating diseases with natural forces such as water, heat, diet, sunshine, stress reduction, physical manipulation, massage, or herbal tea. Note: Naturopathy providers, treatment, services, or substances are not a payable benefit under this Plan.

No Surprises Act means the federal No Surprises Act (Public Law 116-260, Division BB).

Nondurable Supplies: Goods or supplies that cannot withstand repeated use and/or that are considered disposable and limited to either use by a single person or one-time use, including (but not limited to) bandages, hypodermic syringes, diapers, soap, or cleansing solutions, etc. See also the definitions of Corrective Appliances, Durable Medical Equipment, Orthotic Appliance (or Device) and Prosthetic Appliance (or Device). Only those Nondurable Supplies identified in the *Schedule of Medical Benefits* are covered by this Plan. All others are not.

Non-Network: See Out-of-Network.

Non-PPO emergency facility: An emergency department of a hospital, or an independent freestanding emergency department (or a hospital, with respect to Emergency Services as defined), that does not have a contractual relationship directly or indirectly with a group health plan or group health insurance coverage offered by a health insurance issuer, with respect to the furnishing of an item or service under the plan or coverage respectively.

Non-PPO Provider or Non-Participating Provider: A health care provider who does not have a contractual relationship directly or indirectly with the Plan with respect to the furnishing of an item or service under the Plan.

Nurse: A person legally licensed as a Registered Nurse (RN), Certified Registered Nurse Anesthetist (CRNA), Certified Nurse Midwife or licensed Midwife, Nurse Practitioner (NP), Licensed Practical Nurse (LPN), Licensed Vocational Nurse (LVN), Psychiatric Mental Health Nurse, or any equivalent designation, under the laws of the state or jurisdiction where the services are rendered, who acts within the scope of his or her license.

Nurse Anesthetist: A person legally licensed as a Certified Registered Nurse Anesthetist (CRNA), Registered Nurse Anesthetist (RNA) or Nurse Anesthetist (NA) and authorized to administer Anesthesia in collaboration with a physician, and bill and be paid in his or her own name, or any equivalent designation, under the laws of the state or jurisdiction where the services are rendered, who acts within the scope of his or her license.

Nurse Practitioner: A person legally licensed as a Nurse Practitioner (NP), or Registered Nurse Practitioner (RNP) who acts within the scope of his or her license and who in collaboration with a physician, examines patients, establishes medical diagnoses; orders, performs and interprets laboratory, radiographic and other diagnostic tests, identifies, develops, implements and evaluates a plan of patient care, prescribes and dispenses medication, refers to and consults with appropriate health care practitioners under the laws of the state or jurisdiction where the services are rendered.

Occupational Therapist: A person legally licensed as a professional occupational therapist who acts within the scope of their license and acts under the direction of a physician to assess the presence of defects in an individual's ability to perform self-care skills and activities of daily living and who formulates and carries out a plan of action to restore or support the individual's ability to perform such skills to regain independence.

Office Visit: A direct personal contact between a physician or other health care practitioner and a patient in the health care practitioner's office for diagnosis or treatment associated with the use of the appropriate office visit code in the Current Procedural Terminology (CPT) manual of the American Medical Association and with documentation that meets the requirement of such CPT coding. Neither a telephone discussion with a physician or other health care practitioner nor a visit to a health care practitioner's office solely for such services as blood drawing, leaving a specimen, or receiving a routine injection is an office visit for the purposes of this Plan.

Open Enrollment Period: The period during which participants in the Plan may select among the alternate health benefit programs that are offered by the Plan or eligible individuals not currently enrolled in the Plan may enroll for coverage.

Oral Surgery: The specialty of dentistry concerned with surgical procedures in and about the mouth and jaw.

Orthognathic Services: Services dealing with the cause and treatment of malposition of the bones of the jaw, such as Prognathism, Retrognathism or TMJ syndrome. See the definitions of Prognathism, Retrognathism and TMJ.

Orthotic (Appliance or Device): A type of corrective appliance or device, either customized or available "over-the-counter," designed to support a weakened body part, including (but not limited to) crutches, custom designed corsets, leg braces, extremity splints, and walkers. For the purposes of the medical Plan, this definition does not include dental orthotics. See also the definitions of Corrective Appliance, Durable Medical Equipment, Nondurable Supplies and Prosthetic Appliance (or Device).

Other Prescription Drugs: Drugs that require a prescription under state law but not under federal law.

Out-of-Network Rate: With respect to items and services furnished by a Non-PPO provider, Non-Network emergency facility or Non-PPO provider of ambulance services, means one of the following:

- the amount the parties negotiate;
- the amount approved under the independent dispute resolution (IDR) process; or
- if the state has an All-Payer Model Agreement, the amount that the state approves under that system

Out-of-Network Services (Non-Network): Services provided by a health care provider that is not a member of the Plan's Preferred Provider Organization (PPO), as distinguished from In-Network services that are provided by a health care provider that is a member of the PPO. Greater expense could be incurred by the participant when using Out-of-Network providers.

Out-of-Pocket Maximum: The maximum amount of Coinsurance each covered person or family is responsible for paying during a Plan Year before the Coinsurance required by the Plan ceases to apply. When the Out-of-Pocket Maximum is reached, the Plan will pay 100% of eligible covered expenses for the remainder of the Plan Year. See the section on Out-of-Pocket Maximum in the *Medical Expense Coverage* section for details about what expenses do not count toward the Out-of-Pocket Maximum.

Outpatient Hospital Laboratory and Outpatient Hospital-Based Laboratory Draw Station: Outpatient hospital-based laboratory facilities include lab services performed in a hospital outpatient setting. Outpatient hospital-based laboratory draw stations are hospital affiliated whereby the draw station collects specimens and sends them to the central hospital lab for processing.

Outpatient Services: Services provided either outside of a hospital or health care facility setting or at a hospital or health care facility when room and board charges are not incurred.

Partial Hospitalization Service: Also known as PHP, is a type of program used to treat mental illness and substance abuse in which the patient continues to reside at home but commutes to a treatment center up to seven days a week. This service model focuses on the overall treatment of the individual and is intended to avert or reduce in-patient hospitalization. Services are typically provided in either a hospital setting or by a free-standing community mental health center. Treatment during a typical day may include group therapy, psych-educational groups, skill building, individual therapy, and psychopharmacological assessments, and check-ins. Programs are available for the treatment of alcoholism and substance abuse, Alzheimer's disease, anorexia and bulimia, depression, bipolar disorder, anxiety disorders, schizophrenia, and other mental illnesses.

Participant: The employee or retiree or their enrolled spouse or domestic partner or dependent child(ren) or a surviving spouse or dependent of a retiree. NAC 287.095

Participating Provider: A health care provider who participates in the Plan's Preferred Provider Organization (PPO).

Passive Rehabilitation: Refers to therapy in which a patient does not actively participate because the patient does not have the ability to learn and/or remember (that is, has a cognitive deficit), or is comatose or otherwise physically or mentally incapable of active participation. Passive rehabilitation may be covered by the Plan, but only during a course of hospitalization for acute care. Techniques for passive rehabilitation are commonly taught to the family/caregivers to employ on an outpatient basis with the patient when and until the patient can achieve active rehabilitation. Continued hospitalization for the sole purpose of providing passive rehabilitation will not be medically necessary for the purposes of this Plan.

Pharmacy: A licensed establishment where covered prescription drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he or she practices.

Pharmacist: A person legally licensed under the laws of the state or jurisdiction where the services are rendered, to prepare, compound and dispense drugs and medicines, and who acts within the scope of his or her license.

Physical Therapy: Rehabilitation directed at restoring function following disease, injury, surgery, or loss of body part using therapeutic properties such as active and passive exercise, cold, heat, electricity, traction, diathermy, and/or ultrasound to improve circulation, strengthen muscles, return motion, and/or train/retrain an individual to perform Activities of daily living such as walking and getting in and out of bed.

Physician: A person legally licensed as a Medical Doctor (MD) or Doctor of Osteopathy (DO) and authorized to practice medicine, to perform surgery, and to administer drugs, under the laws of the state or jurisdiction where the services are rendered who acts within the scope of his or her license.

Physician Assistant (PA): A person legally licensed as a physician assistant, who acts within the scope of his or her license and acts under the supervision of a physician to examine patients, establish medical diagnoses; order, perform and interpret laboratory, radiographic and other diagnostic tests; identify, develop, implement and evaluate a plan of patient care; prescribe and dispense medication within the limits of his or her license; refer to and consult with the supervising physician; under the laws of the state or jurisdiction where the services are rendered.

Plan, The Plan, This Plan: In most cases, the programs, benefits, and provisions described in this document as provided by the Public Employees' Benefits Program (PEBP).

Plan Administrator: The person or legal entity designated by the Plan as the party who has the fiduciary responsibility for the overall administration of the Plan.

Plan Year: Typically, the 12-month period from July 1 through June 30. PEBP has the authority to revise the Plan Year if necessary. PEBP has the authority to revise the benefits and rates, if necessary, each Plan Year. For medical, dental, vision and pharmacy benefits, all Deductibles, Out-of-Pocket Maximums and Plan Year maximum benefits are determined based on the Plan Year.

Plan Year Deductible: The amount you must pay each Plan Year before the Plan pays benefits.

Plan Year Maximum Benefits: The maximum amount of benefits payable each Plan Year for certain medical expenses incurred by any covered Plan participant (or covered family member of the Plan participant).

Podiatrist: A person legally licensed as a Doctor of Podiatric Medicine (DPM) who acts within the scope of his or her license and who is authorized to provide care and treatment of the human foot (and in some states, the ankle and leg up to the knee) under the laws of the state or jurisdiction where the services are rendered.

Positive Annual Open Enrollment Period: This process requires that each eligible employee or eligible retiree affirmatively make his or her benefit elections during the PEBP annual enrollment period. Even if you do not want to make any coverage changes, you must affirmatively make your elections, or you will be defaulted to self-coverage only under the PEBP base Plan.

Pre-Admission Testing: Laboratory tests and x-rays and other medically necessary tests performed on an outpatient basis, 7 days prior to a scheduled hospital admission or outpatient surgery. The testing must be related to the sickness or injury.

Precertification (preauthorization, prior authorization): Is a process used by the UM company and Pharmacy Benefit Manager to determine if a prescribed procedure, including, but not limited to inpatient admission, concurrent review, DME, outpatient services, or medication are medically necessary before the services and supplies are received. A precertification is not a guarantee of payment.

Preferred Provider Organization (PPO): A group or network of health care providers (e.g., hospitals, physicians, laboratories) under contract with the Plan to provide health care services and supplies at agreed-upon discounted or reduced rates.

Prescribed for a Medically Necessary Indication: The term medically necessary indication means any use of a covered outpatient drug which is approved under the Federal Food, Drug and Cosmetic Act, or the use of which is supported by one or more citations included or approved for inclusion in any of the following compendia: American Hospital Formulary Service Drug Information, United States Pharmacopeia-Drug Information, the DRUGDEX Information System or American Medical Association Drug Evaluations.

Prescription Drugs: For the purposes of this Plan, prescription drugs include:

- Federal Legend Drugs: Any medicinal substance that the Federal Food, Drug, and Cosmetic Act requires to be labeled, "Caution - Federal law prohibits dispensing without prescription".
- Other prescription drugs: drugs that require a prescription under state law but not under federal law; or
- Compound drugs: Any drug that has more than one ingredient and at least one of them is a Federal Legend Drug or a drug that requires a prescription under state law.

Prescription Prior Authorization (PA): Also known as "coverage review," this is a process the Plan's Pharmacy Benefit Manager might use to decide if your prescribed medicine will be covered. The Plan uses this to help control costs and to ensure the medicine being prescribed is an effective treatment for the condition.

Primary Care Physician (PCP): A physician in family practice, internal medicine, obstetrics and gynecology and pediatrics.

Prognathism: The malposition of the bones of the jaw resulting in projection of the lower jaw beyond the upper part of the face.

Program: Means the Public Employees' Benefits Program established in accordance with NRS 287.0402 to 287.049, inclusive.

Prophylactic Surgery: A surgical procedure performed for

1) avoiding the possibility or risk of an illness, disease, physical or mental disorder or condition based on genetic information or genetic testing, or
2) treating the consequences of chromosomal abnormalities or genetically transmitted characteristics, when there is an absence of objective medical evidence of the presence of disease or physical or mental disorder, even at its earliest stages.

An example of prophylactic surgery is a mastectomy performed on a woman who has been diagnosed as having a genetic predisposition to breast cancer or has a history of breast cancer among her family members when, at the time the surgery is to be performed, there is no objective medical evidence of the presence of the disease, even if there is medical evidence of a chromosomal abnormality or genetically transmitted characteristic indicating a significant risk of breast cancer coupled with a history of breast cancer among family members of the woman.

Prophylaxis: The removal of tartar and stains from the teeth. The cleaning and scaling of the teeth are performed by a dentist or dental hygienist.

Prospective Payment System (PPS): This Plan follows CMS's Prospective Payment System (PPS) where the Plan's payment is based on a predetermined, fixed amount payable to a facility for inpatient or outpatient hospital services. The Plan will not allow separate reimbursement for

specific HCPCS supplies, DME, orthotics, prosthetics, biological, and drugs billed on a HCFA claim form by any physician or other qualified healthcare professional in the following facility POS (place of service) 19, 21, 22, 23, and 24, see the following POS descriptions:

- **POS 19 Off Campus – Outpatient Hospital:** A portion of an off-campus hospital provider-based department which provides diagnostic, therapeutic (both surgical and non-surgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.
- **POS 21 Inpatient Hospital:** A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and nonsurgical), rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.
- **POS 22 On Campus – Outpatient Hospital:** A portion of a hospital's main campus which provides diagnostic, therapeutic (both surgical and non-surgical), and rehabilitation services by, or under, the supervision physicians to patients admitted for a variety of medical conditions.
- **POS 23 Emergency Room – Hospital:** A portion of a hospital where emergency diagnosis and treatment of illness and injury is provided.
- **POS 24 Ambulatory Surgery Center:** A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.

Prosthetic Appliance (or Device): A type of corrective appliance or device designed to replace all or part of a missing body part, including (but not limited to) artificial limbs, heart pacemakers, or corrective lenses needed after cataract surgery. See also the definitions of Corrective Appliances, Durable Medical Equipment, Nondurable Supplies and Orthotic Appliance (or Device).

-

Provider: A health care practitioner as defined above, or a hospital, ambulatory surgical facility, behavioral health treatment facility, birthing center, home health care agency, hospice, skilled nursing facility, or sub-acute care facility (as those terms are defined in this *Key Terms and Definitions* Section).

Qualified Individual: A covered individual who is eligible, according to clinical trial protocol, to participate in an approved clinical trial and either: (i) the referring health care professional is an in-network provider and has concluded that the covered individual's participation in the clinical trial would be appropriate; or (ii) the covered individual provided medical and scientific information establishing that the individual's participation in the clinical trial would be appropriate.

Qualified Medical Child Support Orders (QMCSO): QMCSOs are state court orders requiring a parent to provide medical support to a child often because of legal separation or divorce and also include a National Medical Support Notice. A QMCSO may require the Plan to make

coverage available to your child even though, for income tax or Plan purposes, the child is not your dependent. To qualify, a medical support order must be a judgment, decree, or order (including approval of a settlement agreement) issued by a court of competent jurisdiction or by an administrative agency, which:

- Specifies your last known name and address and the child's last known name and address.
- Describes the type of coverage to be provided, or how the type of coverage will be determined.
- States the period to which it applies; and
- Specifies each plan to which it applies.

The QMCSO cannot require the Plan to cover any type or form of benefit that they do not currently cover. The Plan must pay benefits directly to the child, or to the child's custodial parent or legal guardian, consistent with the terms of the order and Plan provisions. You and the affected child will be notified if an order is received.

Qualifying Payment Amount (QPA) means the amount calculated using the methodology described in 29 CFR 716-6(c).

Quantity Limit: The maximum amount of a medication the Plan covers during a period of time. These limits are set for safety reasons and to help reduce costs.

Reasonable and/or Reasonableness: Means charges for services or supplies which are necessary for the care and treatment of an illness or injury. The determination that charges are reasonable will be made by the Plan Administrator taking into consideration the following:

- The facts and circumstances giving rise to the need for the service or supply.
- Industry standards and practices as they are related to similar scenarios; and
- The cause of the injury or illness necessitating the service or charge.

The Plan Administrator's determination will consider but will not be limited to evidence-based guidelines, and the findings and assessments of the following entities:

(a) The National Medical Associations, Societies, and Organizations;
(b) The Centers for Medicare and Medicaid Services (CMS);
(c) Centers for Disease Control and Prevention; and
(d) The Food and Drug Administration.

To be reasonable, charges must follow generally accepted billing practices for unbundling or multiple procedures. The Plan Administrator retains discretionary authority to determine whether a charge is reasonable. The Plan reserves for itself and parties acting on its behalf the right to review charges processed and/or paid by the Plan, to identify charges that are not reasonable and therefore not eligible for payment by the Plan.

Recognized Amount: means (in order of priority) one of the following:

1. An amount determined by an applicable All-Payer Model Agreement under section 1115A of the Social Security Act;
2. An amount determined by a specified state law; or
3. The lesser of the amount billed by the provider or facility or the Qualifying Payment Amount (QPA)

For air ambulance services furnished by Non-PPO providers, **Recognized Amount** is the lesser of the amount billed by the provider or facility or the Qualifying Payment Amount (QPA).

Reconstructive Surgery: A medically necessary surgical procedure performed on an abnormal or absent structure of the body to correct damage caused by a congenital birth defect, an accidental injury, infection, disease, or tumor, or for breast reconstruction following a total or partial mastectomy.

Reference Based Pricing/Reference Price: A methodology that determines the cost for a covered service based on a market or industry benchmark or reference price. The Plan Administrator may utilize this method in determining the Maximum Allowable Charge.

Rehabilitation Therapy: Physical, occupational, or speech therapy that is prescribed by a physician when the bodily function has been restricted or diminished as a result of illness, injury or surgery, with the goal of improving or restoring bodily function by a significant and measurable degree to as close as reasonably and medically possible to the condition that existed before the injury, illness or surgery, or medically necessary treatment of a behavioral health condition, and that is performed by a licensed therapist acting within the scope of his or her license. See the *Schedule of Medical Benefits* and the *Exclusions* section of this document to determine the extent to which rehabilitation therapies are covered. See also the definition of Physical Therapy, Occupational Therapy, Speech Therapy and Cardiac Rehabilitation.

Reimbursable Payments: Payments made by this Plan for benefits, including any payment for a covered pre-existing condition that are or become the responsibility of another party under the subrogation provisions as described in this MPD.

Rescission: A cancellation or discontinuance of coverage under the Plan that has a retroactive effect. Rescission does not include a cancellation or discontinuance of coverage under the Plan if

(a) The cancellation or discontinuance of coverage has only a prospective effect; or

(b) The cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage

Retiree: Unless specifically indicated otherwise, when used in this document, Retiree refers to a person formerly employed by an agency or entity that may or may not participate in the PEBP program and who is eligible to enroll for coverage under this Plan.

Retrognathism: The malposition of the bones of the jaw resulting in the retrogression of the lower jaw from the upper part of the face.

Retrospective Review: Review of health care services after they have been provided to determine if those services were medically necessary and/or if the charges for them are Usual and Customary Charges and do not exceed the Plan's Maximum Allowable Charge or negotiated fee schedule.

Second Opinion: A consultation and/or examination, preferably by a board-certified physician not affiliated with the primary attending physician, to evaluate the medical necessity and advisability of undergoing surgery or receiving a medical service.

Serious and Complex Condition: With respect to a participant, beneficiary, or enrollee under the Plan one of the following:

1. in the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm;
2. in the case of a chronic illness or condition, a condition that is—
    a. is life-threatening, degenerative, potentially disabling, or congenital; and

requires specialized medical care over a prolonged period of time.

Service Area: The geographic area serviced by the In-Network providers who have agreements with the Plan's network.

Sickle Cell Disease: An inherited disease caused by a mutation in a gene for hemoglobin in which red blood cells have an abnormal crescent shape that causes them to block small blood cells and die sooner than normal red blood cells and may include sickle cell disease, one or more variants or a combination thereof, as applicable.

Significantly Inferior Coverage: The PEBP Board has defined Significantly Inferior Coverage as either:

- A mini-med or other limited benefit plan; or
- Catastrophic coverage plans with a Deductible equal to or greater than $5,000 for single coverage with no employer contributions to a Health Savings Account or Health Reimbursement Arrangement.

Skilled Nursing Care: Services performed by a licensed nurse (RN, LVN or LPN) if the services are ordered by and provided under the direction of a physician; and are intermittent and part-time, generally not exceeding 16 hours a day, and are usually provided on less-than-daily basis; and require the skills of a nurse because the services are so inherently complex that they can be safely

and effectively performed only by or under the supervision of a nurse. Examples of skilled nursing care services include but are not limited to the initiation of intravenous therapy and the initial management of medical gases such as oxygen.

Skilled Nursing Facility or Extended Care/Skilled Nursing Facility: A public or private facility, licensed and operated according to law, that primarily provides skilled nursing and related services to people who require medical or nursing care and that rehabilitates injured, sick people or people with disabilities, and that meets all the following requirements:

- Is licensed pursuant to state and local laws.
- Is operated primarily for providing skilled nursing care and treatment for individuals convalescing from injury or illness.
- Is approved by and is a participating facility with Medicare.
- Has organized facilities for medical treatment.
- Provides 24-hour-a-day nursing service under the full-time supervision of a physician or registered nurse.
- Maintains daily clinical records on each patient.
- Has available the services of a physician under an established agreement.
- Provides appropriate methods for dispensing and administering drugs and medicines.
- Has transfer arrangements with one or more hospitals; a utilization review plan in effect; and operational policies developed with the advice of and reviewed by a professional group including at least one physician; and
- Is not an institution which is mainly a rest home; a home for the aged; a place for drug addicts; a place for alcoholics; or a place for the treatment of mental illness.

A skilled nursing facility that is part of a hospital, as defined in this document, will be considered a skilled nursing facility for the purposes of this Plan.

Special Food Product: [NRS 689B.0353] A food product that is specially formulated to have less than one gram of protein per serving and is intended to be consumed under the direction of a physician for the dietary treatment of an inherited metabolic disease. The term does not include a food that is naturally low in protein.

Specialist Physician: A doctor who has completed advanced education and training in a specific field of medicine.

Specialty Care Unit: A section, ward, or wing within a hospital that offers specialized care for the patient's needs. Such a unit usually provides constant observation, special supplies, equipment, and care provided by Registered nurses or other highly trained personnel. Examples include Intensive Care Units (ICU) and Cardiac Care Units (CCU).

Speech Therapy: Rehabilitation directed at treating defects and disorders of spoken and written communication,

Spinal Manipulation / Chiropractic Care: The detection and correction, by manual or mechanical means, of the interference with nerve transmissions and expressions resulting from distortion, misalignment, or dislocation of the spinal (vertebrae) column. Spinal manipulation is commonly performed by chiropractors, but it can be performed by physicians.

Spouse: The employee's lawful spouse. The Plan will require proof of the legal marital relationship. A legally separated spouse or divorced former spouse or domestic partner of an employee or retiree is not an eligible spouse under this Plan.

Standard Plan Benefits (Standard Benefits): Standard Plan Benefits or Standard Benefits under this Plan means the participant is covered under the Plan's Standard Benefits and is not eligible for enhanced benefits due to non-participating and or engaging in the Diabetes Care Management or Obesity Care and Overweight Management Programs.

State: When capitalized in this document, the term State means the State of Nevada.

Step Therapy: A process designed to help control high medicine costs. If the Plan applies step therapy to your medication, it will require that you try a lower-cost medication that is proven effective to treat your condition, before it will cover a higher-cost medicine. If the lower cost medicine does not treat your condition effectively, the Plan's coverage will "step" you to a higher-cost medicine to find a medicine that treats your condition effectively at the lowest possible cost.

The Plan also complies with NRS 689B.0305 and NRS 695C.17333:

Sub-acute Care Facility: A public or private facility, either free-standing, hospital-based or based in a skilled nursing facility, licensed and operated according to law and authorized to provide sub-acute care, that primarily provides, immediately after or instead of acute care, comprehensive inpatient care for an individual who has had an acute illness, injury, or exacerbation of a disease process, with the goal of discharging the patient after a limited term of confinement, to the patient's home or to a suitable skilled nursing facility, and that meets all of the following requirements:

1. It is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) as a Sub-Acute Care Facility or is recognized by Medicare as a Sub-Acute Care Facility; and
2. It maintains on its premises all facilities necessary for medical care and treatment; and
3. It provides services under the supervision of physicians; and
4. It provides nursing services by or under the supervision of a licensed Registered Nurse; and

5. It is not (other than incidentally) a place for rest, domiciliary care, or care of people who are aged, alcoholic, blind, deaf, drug addicts, mentally deficient, or suffering from tuberculosis; and
6. It is not a hotel or motel.

Substance Abuse: A psychological and/or physiological dependence or addiction to alcohol or drugs or medications, regardless of any underlying physical or organic cause, and/or other drug dependency as defined by the current edition of the ICD manual or identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM). See the definitions of behavioral health disorders and chemical dependency.

Surgery/Surgeries: Any operative or diagnostic procedure performed in the treatment of an injury or illness by instrument or cutting procedure through an incision or any natural body opening. When more than one surgical procedure is performed through the same incision or operative field or at the same operative session, the claims administrator will determine which multiple surgical procedures will be considered as primary, secondary, bilateral, add-on, or separate (incidental) procedures for determining benefits under this Plan.

Multiple Surgical Procedure Allowances:

- Primary procedure, bilateral primary procedure, or add-on to primary procedure: usual and customary, subject to the Plan's Maximum Allowable Charge or negotiated fee.
- Secondary procedure in same operative area: limited to 50% of usual and customary charge, subject to the Plan's Maximum Allowable Charge or negotiated fee.
- Bilateral secondary procedure in same operative area: limited to 50% of usual and customary charge, subject to the Plan's Maximum Allowable Charge or negotiated fee.
- Add-on to secondary procedure in same operative area: limited to 100% of usual and customary charge, subject to the Plan's Maximum Allowable Charge or negotiated fee.
- Separate (incidental) procedure in same operative area as any of the above: not covered.
- Separate operative area: limited to 50% of usual and customary charge, subject to the Plan's Maximum Allowable Charge or negotiated fee.

Telehealth: Telehealth means the delivery of services from a provider of health care to a patient at a different location using information and audio-visual communication technology, not including facsimile, or electronic mail. See also NRS 629.515

Telehealth is a general term used to describe clinical services provided to patients through electronic communications not through a vendor. This can be patient-to-physician. Examples include patient consultation with a specialist that is out of the patient's geographical area or patient has a virtual visit with their primary care physician. Telehealth is the use of digital

information and communication technologies, such as computers and mobile devices, to access health care services remotely and manage your health.

Telemedicine: Telemedicine (vendor/virtual visit) is the practice of medicine using technology to deliver care at a distance via electronic communications through a vendor.

Temporomandibular Joint (TMJ), Temporomandibular Joint (TMJ) Dysfunction or Syndrome: The Temporomandibular (or craniomandibular) Joint (TMJ) connects the bone of the temple or skull (temporal bone) with the lower jawbone (the mandible). TMJ Dysfunction or Syndrome refers to a variety of symptoms where the cause is not clearly established, including (but not limited to) masticatory muscle disorders producing severe aching pain in and about the TMJ (sometimes made worse by chewing or talking); myofascial pain, headaches, earaches, limitation of the joint, clicking sounds during chewing; tinnitus (ringing, roaring, or hissing in one or both ears) and/or hearing impairment. These symptoms may be associated with conditions such as malocclusion (failure of the biting surfaces of the teeth to meet properly), ill-fitting dentures, or internal derangement of the TMJ.

Termination: Includes, with respect to the Continuation of Care benefit, the expiration or nonrenewal of the contract, but does not include a termination of the contract for failure to meet applicable quality standards or for fraud.

Therapist: A person trained in and skilled in giving therapy in a specific field of health care such as occupational, physical, radiation, respiratory and speech therapy. *See the Occupational, Physical and Speech Therapy* section.

1.

Tortfeasor: Means an individual or entity who commits a wrongful act, either intentionally or through negligence, that injures another or for which the law provides a legal right through a civil case for the injured person to seek relief.

Transplant, Transplantation: The transfer of organs (such as the heart, kidney, liver) or living tissue/cells (such as bone marrow, stem cells or skin) from a donor to a recipient with the intent to maintain the functional integrity of the transplanted organ or tissue in the recipient. (See the *Schedule of Medical Benefits* and *Exclusions* section for additional information regarding transplants. See also the *Utilization Management* section of this document for information about precertification requirements for transplantation services).

Xerographic: Refers to transplants of organs, tissues, or cells from one species to another (for example, the transplant of an organ from a baboon to a human). Xerographic transplants are not covered by this Plan, except heart valves.

Urgent Care: Health care services that are required by the onset of a medical condition that manifests itself by symptoms of sufficient severity that prompt medical attention is appropriate, even though health and life are not in jeopardy. Examples of medical conditions that may be appropriate for urgent care include (but are not limited to) fever, sprains, bone, or joint injuries, continuing diarrhea, or vomiting, or bladder infections.

Urgent Care Claim: Means a claim for benefits that is treated in an expedited manner because the application of the time periods for making determinations that are not urgent care claims could seriously jeopardize the participant's life, health, or the ability to regain maximum function by waiting for a routine appeal decision. An urgent care claim also means a claim for benefits that, in the opinion of a physician with knowledge of the participant's medical conditions, would subject the participant to severe pain that cannot be adequately managed without the care or the treatment that is the subject of the claim. If an original request for precertification of an urgent care service was denied, the participant could request an expedited appeal for the urgent care claim.

Urgent Care Facility: A public or private hospital-based or free-standing facility, that includes x-ray and laboratory equipment and a life support system, licensed or legally operating as an urgent care facility, primarily providing minor emergency and episodic medical care with one or more physicians, nurses, and x-ray technicians in attendance when the facility is open.

Usual and Customary: Covered expenses which are identified by PEBP, taking into consideration the fee(s) which the provider most frequently charges (or accepts for) most patients for the service or supply, the cost to the provider for providing the services, the prevailing range of fees charged in the same "area" by providers of similar training and experience for the service or supply, and the Medicare reimbursement rates. The term(s) "same geographic locale" and/or "area" shall be defined as a metropolitan area, country, or such greater area as is necessary to obtain a representative cross- section of providers, persons or organizations rendering such treatment, services, or supplies for which a specific charge is made.

To be Usual and Customary, fee(s) must follow generally accepted billing practices for unbundling or multiple procedures.

The term "Usual" refers to the amount of a charge made or accepted for medical services, care, or supplies, to the extent that the charge does not exceed the common level of charges made by other medical professionals with similar credentials, or health care facilities, pharmacies, or equipment suppliers of similar standing, which are in the same geographic locale in which the charge is incurred.

The term "Customary" refers to the form and substance of a service, supply, or treatment provided in accordance with generally accepted standards of medical practice to one individual, which is appropriate for the care or treatment of the same sex, comparable age and who receive such services or supplies within the same geographic locale.

The term "Usual and Customary" does not necessarily mean the actual charge made nor the specific service or supply furnished to a participant by a provider of services or supplies, such as

a physician, therapist, nurse, hospital, or pharmacist. The Plan Administrator will determine what the Usual and Customary charge is, subject to the Plan's Maximum Allowable Charge or negotiated fee schedule for any procedure, service, or supply, and whether a specific procedure, service or supply is usual and customary. Usual and customary charges may, at the Plan Administrator's discretion, alternatively be determined and established by the Plan using normative data such as, but not limited to, Medicare cost to charge ratios, Average Wholesale Price (AWP) for prescriptions and/or manufacturer's retail pricing (MRP) for supplies and devices.

Utilization Management (UM): A managed care process to determine the medical necessity, appropriateness, location, and cost-effectiveness of health care services. This review can occur before, during or after the services are rendered and may include (but is not limited to): precertification; concurrent and/or continued stay review; discharge planning; retrospective review; case management; hospital or other health care provider bill audits; and health care provider fee negotiation. Utilization management services (sometimes referred to as UM services, UM, utilization review services, UR services, utilization management, concurrent review, or retro review services) are provided by licensed health care professionals employed by the utilization management company operating under a contract with the Plan.

Utilization Management Company (UM company): The independent utilization management organization, staffed with licensed health care professionals, who utilize nationally recognized health care screening criteria along with the medical judgment of their licensed health care professional, operating under a contract with the Plan to administer the Plan's utilization management services.

Visit: See the definition of office visit.

Well Baby Care; Well Child Care: Health care services provided to a healthy newborn or child that are determined by the Plan to be medically necessary, even though they are not provided because of illness, injury, or congenital defect. The Plan's coverage of well-baby care is described under *Preventive Care/Wellness Services* and in the *Schedule of Medical Benefits*.

You, Your: When used in this document, these words refer to the employee or retiree who is covered by the Plan. They do not refer to any dependent of the employee or retiree.

NEVADA PUBLIC EMPLOYEES' BENEFITS PROGRAM

Access.
Quality.
Affordability.

PPO (LOW DEDUCTIBLE) PLAN
MASTER PLAN DOCUMENT

PLAN YEAR 2024

(EFFECTIVE JULY 1, 2023 – JUNE 30, 2024)

Public Employees' Benefits Program
901 S. Stewart Street, Suite 1001
Carson City, Nevada 89701

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Amendment Log

Any amendments, changes or updates to this document will be listed here. The amendment log will include what sections are amended and where the changes can be found.

Welcome PEBP Participant

Welcome to the State of Nevada Public Employees' Benefits Program (PEBP). PEBP offers medical, vision, dental, and life insurance, in addition to flexible spending accounts, and other voluntary benefits for eligible state and local government employees, retirees, and their eligible dependents.

As a PEBP participant, you may access whichever benefit plan offered in your geographical area that best meets your needs, subject to specific eligibility and Plan requirements. These plans include the Consumer Driven Health Plan (CDHP) with a Health Savings Account (HSA) or a Health Reimbursement Arrangement (HRA), EPO Plan, Low Deductible PPO Plan, and the Health Plan of Nevada HMO Plan. You are also encouraged to research plan provider access and quality of care in your service area.

All PEBP participants choosing the Low Deductible Health Plan should examine this document, the PEBP Self-Funded PPO Dental Plan Master Plan Document (MPD), the Active Employee Health and Welfare Wrap Plan, Retiree Health and Welfare Wrap Plan, Section 125 Document, and the PEBP Enrollment and Eligibility Master Plan Document. These documents are available at www.pebp.state.nv.us or by calling 775-684-7000, 702-486-3100, or 1-800-326-5496.

Master Plan Documents are a comprehensive description of the benefits available to you. Relevant statutes and regulations are noted in the Active Employee Health and Welfare Plan Document and Retiree Health and Welfare Wrap Plan Document for reference. In addition, helpful material is available from PEBP or any PEBP vendor listed in the *Participant Contact Guide*.

PEBP encourages you to stay informed of the most up to date information regarding your health care benefits. It is your responsibility to know and follow the requirements as described in PEBP's Master Plan Documents.

Sincerely,

Public Employees' Benefits Program

Introduction

This Master Plan Document describes the Low Deductible PPO Plan (also referred to as the LD PPO Plan). The LD PPO Plan offers In-Network and Out-of-Network benefits and is a self-funded plan administered by PEBP and governed by the State of Nevada. The Plan is available to eligible employees, retirees, and their eligible dependents participating in the Public Employees' Benefits Program (PEBP).

The benefits offered with the LD PPO Plan include medically necessary medical, behavioral health, prescription drug, vision, and dental coverage. Additional benefits include basic life insurance for active employees and eligible retirees. The medical, behavioral health, prescription drug and vision benefits are described in this document. For information regarding the dental and life insurance benefits, refer to the PEBP PPO Dental Plan and Summary of Benefits for Life Insurance Master Plan Document.

An independent third-party Claims Administrator pays the claims for the medical, dental and vision benefits. An independent pharmacy benefit manager pays the claims for prescription drug benefits.

This document is intended to comply with the Nevada Revised Statutes (NRS) Chapter 287, and the Nevada Administrative Code (NAC) 287 as amended and certain provisions of NRS 695G and NRS 689B. The Plan Sponsor certifies that this Article incorporates the provisions set forth in 45 CFR Section 164.504(f)(2)(ii) and the Plan Sponsor agrees to such provisions in accordance with 45 CFR Section 164.504(f)(2)(ii).

The Plan described in this document is effective **July 1, 2023**, and unless stated differently, replaces all other LD PPO Plan medical and prescription drug benefit plan documents/summary plan descriptions previously provided to you.

All provisions of this document contain important information. It will help you understand and use the benefits provided by this Plan. You should review it and show it to members of your family who are or will be covered by the Plan. It will give you an understanding of the coverage provided, the procedures to follow in submitting claims, and your responsibilities to provide necessary information to the Plan. Be sure to read the *Benefit Limitations and Explanations* and *Key Terms and Definitions* sections. Remember, not every expense you incur for health care is covered by this Plan.

PEBP intends to maintain this Plan indefinitely, but reserves the right to terminate, suspend, discontinue, or amend the Plan at any time and for any reason. Members should keep informed of this document as the Plan is amended from time to time. If those later notices describe a benefit or procedure that is different from what is described here, you should rely on the later information. Be sure to keep this document, along with notices of any Plan changes, in a safe and convenient place where you and your family can find and refer to them.

Per NRS 287.0485 no officer, employee, or retiree of the State has any inherent right to benefits provided under the PEBP.

Suggestions for Using this Document:

This document provides important information about your benefits. We encourage you to pay attention to the following:

- The *Table of Contents* provides you with an outline of the sections.
- The *Participant Contact Guide* helps you become familiar with PEBP vendors and the services they provide.
- The *Participant Rights* section describes your rights and responsibilities as a participant of this Plan.
- The *Key Terms and Definitions* section explains many technical, medical, and legal terms that appear in the text.
- The *Eligible Medical Expenses* and *Non-Eligible Medical Expenses*, *Summary of the Low Deductible PPO Plan Components, Schedule of Medical Benefits, Key Terms and Definitions,* and ***Benefit Limitations and Exclusions*** sections describe your benefits in more detail.
- The *Schedule of Medical Benefits* section provides wellness information that can help you proactively manage your health.
- The *Utilization Management* section provides information on what health care services that require prior authorization and the process to request prior authorization.
- The *Claims Administration* section describes how benefits are paid and how to file a claim.
- The *Appeals Procedure* section describes how to request a review (appeal) if you are dissatisfied with a claim decision.
- The *Coordination of Benefits* section describes situations where you have coverage under more than one health care plan, including Medicare.

Accessing Other Benefit Information:

You will also want to access the following documents for information related to dental, life, flexible spending accounts, enrollment and eligibility, Consolidated Omnibus Budget Reconciliation Act (COBRA), third-party liability and subrogation, Health Insurance Portability and Accountability Act (HIPAA) and Privacy and Security and mandatory notices. These documents are available at www.pebp.state.nv.us.

- State of Nevada PEBP Active Employee Health and Welfare Wrap Plan Document
- State of Nevada PEBP Retiree Health and Welfare Wrap Plan Document
- Consumer Driven Health Plan (CDHP) Master Plan Document
- CDHP Summary of Benefits and Coverage for Individual and Family
- Low Deductible PPO Plan Master Plan Document

- Low Deductible PPO Plan Summary of Benefits and Coverage for Individual and Family
- PEBP PPO Dental Plan and Summary of Benefits for Life Insurance Master Plan Document
- EPO Plan Master Plan Document
- EPO Plan Summary of Benefits and Coverage for Individual and Family
- Health Plan of Nevada Evidence of Coverage (EOC) and Summary of Benefits and Coverage
- PEBP Enrollment and Eligibility Master Plan Document
- Flexible Spending Accounts (FSA) Summary Plan Description
- Section 125 Health and Welfare Benefits Plan Document
- Medicare Retiree Health Reimbursement Arrangement Summary Plan Description

Participant Rights

You have the right to:

- Participate with your health care professionals in your health care decisions and have your health care professionals give you information about your condition and your treatment options.
- Receive the benefits for which you have coverage.
- Be treated with respect and dignity.
- Privacy of your personal health information, consistent with State and Federal laws, and the Plan's policies.
- Receive information about the Plan's organization and services, the Plan's network of health care professionals and providers and your rights.
- Candidly discuss with your physicians and providers appropriate or medically necessary care for your condition, regardless of cost or benefit coverage.
- Make recommendations regarding the organization's participants' rights and responsibilities policies.
- Express respectfully and professionally, any concerns you may have about PEBP or any benefit or coverage decisions the Plan, or the Plan's designated administrator, makes.
- Refuse treatment for any conditions, illness, or disease without jeopardizing future treatment and be informed by your physician(s) of the medical consequences.

Summary of the LD PPO Components

Highlights of the Plan

The Low Deductible PPO Plan is a PEBP administered preferred provider organization (PPO) low deductible plan which provides both In-Network and Out-of-Network benefits. As a member, you receive coverage for many medically necessary services and supplies, subject to any Plan *Benefit Limitations and Exclusions*. This is an open access PPO Plan and does not require a referral to see a specialist.

The Plan includes:

- Coverage for participants residing nationwide (in-and outside of Nevada).
- In-and Out-of-Network benefits.
- Reimbursement for *Eligible Medical Expenses* described in this document (and as determined by the Plan Administrator) for participants residing permanently, part time, or while traveling outside of the United States. Refer to the *Out-of-Country Medical, Prescription Drug, and Vision Purchases* section for more information.
- Coverage for eligible preventive care services at 100% when using In-Network providers. Refer to the *Schedule of Medical Benefits* section for more information.
- Health care resources and tools to assist you in making informed decisions about your and your family's health care services. For more information log in to your E-PEBP member portal account at *www.pebp.state.nv.us*.

Plan Year Deductibles and Out-of-Pocket Maximums				
	In-Network Deductible	**In-Network Out-of-Pocket Maximum**	**Out-of-Network Deductible**	**Out-of-Network Out-of-Pocket Maximum**
Individual (self-only coverage)	$0	$4,000	$500	$10,600
Family	Family: $0 Individual family member: None	Family: $8,000 Individual family Member: $4,000	Family: $1,000 Individual family member: $500	$21,200
In-Network and Out-of-Network Deductibles and Out-of-Pocket Maximums are not interchangeable. The Deductibles and Out-of-Pocket Maximums accumulate separately for In-Network and Out-of-Network provider expenses. See Family Deductible explanation below.				

Deductibles

The Plan Year Deductibles (combined medical and prescription drug) includes two tiers:

- **Individual Deductible**: Applies when only one person is covered on the Plan (self-only coverage).
- **Family Deductible**: Applies when two or more individuals are covered on the same Plan (e.g., Employee plus Spouse, Employee plus Spouse and Child, etc.). The Family Deductible may be met through a combination of *Eligible Medical Expenses* from all covered family members. The In-Network Family Deductible includes a "Individual Family Member" embedded Deductible. This means one single member of the family is only required to meet the Individual Family Member Deductible before the Plan starts to pay Coinsurance for that member.

The Individual and Family Deductibles start July 1st (the first day of the Plan Year) and reset the following Plan Year on July 1st. This Plan does not include a Deductible carryover or rollover provision.

During the Plan Year, you are responsible for paying for your eligible medical and prescription drug expenses (except eligible Preventive Services provided In-Network), including amounts exceeding the Plan's reference-based pricing for hip and knee replacement, preauthorization penalties, out of pocket.

In-Network Individual Deductible

The In-Network Individual Deductible applies when only one person is covered on the Plan. For this Plan Year, the Deductible is **$0**. Participants are responsible for paying Out-of-Pocket for eligible medical and prescription drug expenses that are subject to the Deductible. Once the Individual Deductible is met, the Plan will pay its cost-share of eligible benefits. (In-Network and Out-of-Network Deductibles are not interchangeable, meaning the Deductibles accumulate separately for In-Network provider expenses and Out-of-Network provider expenses.) Deductible credit is based on the date the medical or prescription drug expense is received by the Plan and not on the date of service.

Out-of-Network Individual Deductible

The Out-of-Network Individual Deductible applies when only one person is covered on the Plan. For this Plan Year, the Deductible for Eligible Medical Expenses received Out-of-Network is **$500**. Participants are responsible for paying Out-of-Pocket for eligible medical (prescription drugs are not covered Out-of-Network) expenses up to the Plan Year Deductible. Once the Individual Deductible is met, the Plan will pay its cost-share of eligible benefits. (In-Network and Out-of-Network Deductibles are not interchangeable, meaning the Deductibles accumulate separately for In-Network provider expenses and Out-of-Network provider expenses.) Deductible credit is

based on the date the medical or prescription drug expense is received by the Plan and not on the date of service.

In-Network Family Deductible

The In-Network Family Deductible applies when two or more individuals are covered on the same Plan. For this Plan Year, the Family Deductible is **$0** and includes a **$0** embedded "Individual Family Member" Deductible. For a participant covered with one or more dependents, this Plan will pay benefits for eligible In-Network medical and prescription drug expenses for the entire family after the **$0** Family Deductible is met; or the Plan will pay benefits for one single family member who has met the **$0** "Individual Family Member" Deductible (under no circumstances will one single family member be required to pay more than **$0** toward the **$0** Family Deductible). The **$0** In-Network Family Deductible may be met by any combination of Eligible Medical Expenses from *two or more* covered individuals in the family. The Family Deductible (including "Individual Family Member" Deductible) accumulates separately for In-Network provider and Out-of-Network provider expenses. Deductible credit is based on the date the medical or prescription drug expense is received by the Plan and not on the date of service.

Out-of-Network Family Deductible

The Out-of-Network Family Deductible applies when two or more individuals are covered on the same Plan. For this Plan Year, the Family Deductible is **$1,000** and includes a **$500** "Individual Family Member" Deductible. For a participant covered with one or more dependents, this Plan will pay benefits for eligible Out-of-Network medical and vision (prescription drugs are not covered Out-of-Network) expenses for the entire family after the **$1,000** Family Deductible is met; or the Plan will pay benefits for one single family member who has met the **$500** "Individual Family Member" Deductible (under no circumstances will one single family member be required to pay more than **$500** toward the **$1,000** Out-of-Network Family Deductible). The **$1,000** Family Deductible may be met by any combination of Eligible Medical Expenses from *two or more* covered individuals in the family. The Family Deductible (including "Individual Family Member" Deductible) accumulates separately for In-Network provider and Out-of-Network provider expenses. Deductible credit is based on the date the medical or prescription drug expense is received by the Plan and not on the date of service.

Coinsurance

Coinsurance is the percentage of costs that generally you and the Plan pay for Eligible Medical Expenses. after your Deductible is met. If you receive covered health care services using a health care provider who is a participating provider of this Plan's PPO network, you will be paying less money out of your pocket. This Plan generally pays **80%** of the In-Network provider's contract rate and you are responsible for paying the remaining **20%**. If you use an Out-of-Network provider (a non-participating provider, meaning the provider is not contracted with the PPO network), the Plan benefit may be reduced to **50%** of the Maximum Allowable Charge, and you are responsible for paying the remaining **50%**. Out-of-Network providers can also bill you directly for any difference between their billed charges and the Maximum Allowable Charge allowed by this Plan, except where prohibited by law.

Copayments

Copayments apply as specifically stated in this document and are payable by the covered participant. Copayments do not apply towards the Deductible but do apply towards the Out-of-Pocket Maximum.

Out-of-Pocket Maximums

In-Network Out-of-Pocket Maximums

The In-Network Out-of-Pocket Maximum (OOP Maximum) is the maximum amount you will pay for In-Network eligible medical and prescription drug expenses during the Plan Year. The Out-of-Pocket costs you pay toward your Deductible and Coinsurance for Eligible Medical Expenses accumulate toward your OOP Maximum. The OOP Maximum for:

- An Individual (covered as self-only) is **$4,000**
- Family coverage (participant plus one or more covered dependents) is **$8,000**
    - The Family OOP Maximum includes a **$4,000** embedded "Individual Family Member" OOP Maximum. An Individual Family Member OOP Maximum means one single family member will not pay more than **$4,000** in the Plan Year for Eligible Medical Expenses.

Once an Individual or Family satisfies the OOP Maximum, the Plan will pay 100% of all eligible medical and prescription drug expenses for the remainder of the Plan Year. The OOP Maximum accumulates on a Plan Year basis and resets to zero at the start of a new Plan Year. The accumulation of Eligible Medical Expenses toward the OOP Maximum is based on the date the medical or prescription drug expense is received by the Plan and not on the date of services.

Only Eligible Medical Expenses that apply to the Deductible and Coinsurance will apply to the OOP Maximum. The OOP Maximum does not include premiums, cost-sharing for non-covered supplies and services, expenses associated with denied claims, ancillary charges, preauthorization penalties, amounts exceeding the Plan's allowable charge for hip and knee replacement and amounts that Out-of-Network providers bill and are payable that are greater than this Plan's Maximum Allowable Charge. This list is not all inclusive and may not include certain services and supplies that are not listed here.

For this section only, all references to the OOP Maximum, Eligible Medical Expenses, Deductible and Coinsurance are specific to In-Network benefits.

Out-of-Network Out-of-Pocket Maximum

The Out-of-Network Out-of-Pocket Maximum (OOP Maximum) is the maximum amount you will pay for Eligible Medical Expenses (excluding prescription drugs) during the Plan Year. The Out-of-Pocket costs you pay toward your Deductible and Coinsurance for Eligible Medical Expenses accumulate toward your OOP Maximum. The OOP Maximum for:

- Individual (covered as self-only) is **$10,600.**
- Family coverage (participant plus one or more covered dependents) is **$21,200**. (The Family coverage tier does not include an embedded Individual Family Member OOP Maximum.)

Once the OOP Maximum is met, the Plan will pay 100% of all Eligible Medical Expenses (excluding Out-of-Network prescription drug expenses) for the remainder of the Plan Year. The OOP Maximum accumulates on a Plan Year basis and resets to zero at the start of a new Plan Year.

The accumulation of Eligible Medical Expenses toward the OOP Maximum is based on the date the medical expense is received by the plan and not on the date of services.

The Family OOP Maximum (for Out-of-Network services only) can be met by one person or by a combination of Out-of-Pocket Eligible Medical Expenses from all covered family members.

Only Eligible Medical Expenses that apply to the Deductible and Coinsurance will apply to the OOP Maximum. The OOP Maximum does not include premiums, cost-sharing for non-covered supplies and services, expenses associated with denied claims, ancillary charges, preauthorization penalties, amounts exceeding the Plan's allowable charge for hip and knee replacement, and any amount that Out-of-Network providers bill and are payable that are greater than this Plan's Maximum Allowable Charge. This list is not all inclusive and may not include certain services and supplies that are not listed here.

All references to the Out-of-Network, OOP Maximum, Eligible Medical Expenses, Deductible and Coinsurance in this section are specific to Out-of-Network benefits.

In- and Out-of-Network Maximums are not interchangeable and cannot be combined to reach your Plan Year OOP Maximum.

Description of In-Network and Out-of-Network

Provider Network

The Plan or its designee arranges for providers to participate in a PPO network. For more information, see the Participant Contact Guide section of this document. In-Network providers are hospitals, physicians, medical laboratories, and other health care providers located within a service area who have agreed to provide health care services and supplies at negotiated discount fees. Network providers are not the Plan's employees or employees of any Plan designee.

The contracted PPO Network is responsible for credentialing providers by confirming public information about the providers' licenses and other credentials but does not assure the quality of the services provided.

Before obtaining services, you should always verify the network status of a provider. A provider's status may change. You are responsible for verifying a provider's network status prior to receiving services, even when you are referred by another In-Network provider. You can verify the provider's status by calling the third-party administrator or on the PEBP website in the Find a Provider section. The provider listing is maintained and updated by the contracted network.

It is possible that you might not be able to obtain specific services from an In-Network provider. The provider network is subject to change. Or you might find that an In-Network provider may not be accepting new patients. If a provider leaves the network or is otherwise not available, you must choose another In-Network provider to get In-Network benefits.

Do not assume that an In-Network provider's agreement includes all Eligible Medical Expenses. Some In-Network providers agree to provide only certain covered expenses, but not all covered expenses. Some In-Network providers choose to be an In-Network provider for only some products and services. You may contact the third-party administrator for assistance in choosing a provider or with questions about a provider's network participation.

In-Network Provider Benefits

The Plan provides In-Network benefits when the services are provided by an In-Network provider and generally pays at a higher amount than Out-of-Network benefits. In-Network benefits are payable for covered Eligible Medical Expenses.

When a participant uses the services of a PPO network (In-Network) health care provider, the participant is responsible for paying the applicable Copay, Deductible, and Coinsurance on the discounted fees for medically necessary services or supplies, subject to the Plan's coverage, limitations, and exclusions.

If you receive medically necessary services or supplies from an In-Network provider, you will pay a lower Coinsurance than if you received those services or supplies from a health care provider who is not in the PPO network (Out-of-Network). In-Network providers have agreed to accept the Plan's payment (plus any applicable Coinsurance you are responsible for paying) as payment

in full. The In-Network health care provider generally deals with the Plan directly for any additional amount due.

Out-of-Network Provider Benefits

Out-of-Network Eligible Medical Expenses are subject to applicable Copayments , Deductibles, and a Coinsurance rate of 50% of eligible billed charges and subject to the Plan's Maximum Allowable Charge, except when prohibited by law

Out-of-Network health care providers have no agreements with the Plan and are generally free to set their own charges for the services or supplies they provide. The Plan will pay benefits based on the Maximum Allowable Charge (as defined in the Key Terms and Definitions) on non-discounted medically necessary services or supplies, subject to the Plan's Copays , Deductibles, and Coinsurance. With exception of services subject to the No Surprises Act, Out-of-Network health care providers can bill the participant for any balance that may be due in addition to the amount paid by the Plan (called balance billing). Balance billing for Eligible Medical Expenses can avoided by using In-Network Providers.

Other Providers

If you have a medical condition that the third-party administrator or the utilization management company believes needs special services, they may direct you to a provider identified by them. If you require certain complex covered services for which expertise is limited, the third-party administrator or the utilization management company may direct you to an Out-of-Network provider. In both cases, benefits will only be paid at the In-Network benefit level (subject to the Maximum Allowable Charge) if your covered expenses for that condition are provided by or arranged by the other provider as chosen by third-party claims administrator or the utilization management company.

Participants may obtain health care services from In-Network or Out-of-Network health care providers. Because providers are added and dropped from the PPO network periodically throughout the year, it is the participant's responsibility to verify provider participation before receiving services by contacting the third-party claims administrator at the telephone number or by visiting the provider network's website located at www.pebp.state.nv.us.

Out-of-Network Benefit Exceptions

If there is no In-Network provider within 50-miles of your home, you may be eligible to receive benefits for certain Eligible Medical Expenses paid at the In-Network level, subject to the Plan's Maximum Allowable Charge (with exception of services subject to the No Surprises Act). Benefits that fall under this category must be approved prior to receipt of the care and are subject to any Plan limitations or exclusions set forth in this MPD.

If you are traveling outside your network and you need medical care, you should contact the third-party administrator at the telephone number appearing on your medical identification card for assistance in locating the nearest In-Network provider. If you need emergency care, however,

go ahead and get the care you need. The Plan will pay your claim for Eligible Medical Expenses at the In-Network provider level.

Emergency Care

The Plan provides benefits for emergency care when required for stabilization and initiation of treatment as provided by or under the direction of a health care provider. Eligible Medical Expenses that are provided as a result of Emergent care provided by In-Network providers are paid at the In-Network benefit level. Out-of-Network Emergent care for Eligible Medical Expenses is paid at the In-Network benefit level.,

Confinement in an Out-of-Network Hospital Following an Emergency

If you are confined in an Out-of-Network hospital after you receive emergency services, the utilization management company must be notified within two business days or on the same day of admission if reasonably possible. The UM company may elect to transfer you to an In-Network hospital as soon as it is medically appropriate to do so. If you choose to stay in the Out-of-Network hospital after the date the utilization management company decides a transfer is medically appropriate, and the provider obtains informed consent, and you receive the required notice as required under the No Surprises Act, the Plan will pay Eligible Medical Expenses at the Out-of-Network benefit level, subject to the Plan's Maximum Allowable Charge if the continued stay is authorized by the UM company and determined to be a covered service.

Other Exceptions

If you receive ancillary services such as an x-ray, laboratory services, or anesthesia services from an Out-of-Network provider while receiving services at an In-Network inpatient or outpatient facility (such as an outpatient surgery center), the Plan will cover the Eligible Medical Expenses at the In-Network benefit level, subject to the Plan's Maximum Allowable Charge. Services subject to the No Surprises Act are subject to the Recognized Amount.

When Out-of-Network Providers May be Paid as In-Network Providers

When a participant uses the services of an Out-of-Network provider for Eligible Medical Expenses in the circumstances defined below, charges by the Out-of-Network provider will be subject to the Plan's Maximum Allowable Charge (as defined in the *Key Terms and Definitions* section). Out-of-Network providers may bill the participant for any balance that may be due in addition to the amount paid by the Plan (called balance billing).

- If a participant traveling to an area serviced by an In-Network provider experiences an urgent but not life-threatening situation and cannot access an In-Network provider, benefits may be paid at the In-Network benefit level for use of an Out-of-Network urgent care facility.
- In the event of a life-threatening emergency in which a participant uses an Out-of-Network urgent care.
- For medically necessary services or supplies when such services or supplies are not available from an In-Network provider within 50 driving miles of the

participant's residence. This includes services provided for wellness/preventive, or a second opinion.

- Participant travels to an area not serviced by an In-Network provider within 50 miles.
- If a participant travels to an area serviced by an In-Network provider, the participant must use an In-Network provider to receive benefits at the In-Network benefit level.
- If there is a specialty not available inside the participant's eligible PPO network, benefits may be paid as In-Network.

Preferred Provider Organizations (PPO Network)

A preferred provider organization (PPO) network is a list of the doctors, other health care providers, and hospitals that the Plan has a contract with to provide medical care for Plan members. These providers are called "network providers" or "In-Network providers."

This Plan includes a PPO network for members residing in-and outside-of Nevada. To locate an In-Network provider visit the PEBP website at www.pebp.state.nv.us or contact the third-party claims administrator. Information regarding the PPO network is also available in the *Participant Contact Guide* section of this document.

Service Area

A "Service Area" is a geographic area serviced by In-Network health care providers. If you and or your covered dependent(s) live more than 50 driving miles from the nearest In-Network health care provider whose services or supplies are determined by the Plan Administrator or its designee as being appropriate for the condition being treated, the Plan will consider that you live outside the service area. In that case, your claim for medically necessary services or supplies from an Out-of-Network health care provider will be treated as if the services or supplies were provided In-Network, subject to the Maximum Allowable Charge.

Directories of Network Providers

Participants are encouraged to confirm the In-Network participation status of a provider prior to receiving services.

A list of PPO providers is available to you without charge by visiting the website or by calling the phone number on your ID card. The network consists of providers, including hospitals, of varied specialties as well as general practice, who are contracted with the Plan or an organization contracting on its behalf. The list of PPO providers is maintained and updated by the contracted network.

If you obtain and rely upon incorrect information about whether a provider is a PPO provider from the Plan or its administrators, the Plan will apply PPO cost-sharing to your claim, even if the provider was Non-PPO.

Eligible Medical Expenses

You are covered for expenses you incur for most, but not all, medical services, and supplies. The expenses for which you are covered are called eligible medical expenses. Eligible medical expenses are limited to the covered benefits specified in the *Schedule of Medical Benefits* and are:

- Determined by the Plan Administrator or its designee to be medically necessary (unless otherwise stated in this Plan), but only to the extent that the charges are usual and customary (U&C), provided in-network, and/or do not exceed the Plan's Maximum Allowable Charge, costs that do not exceed the Plan's reference based pricing for services performed at exclusive facilities; (as those terms are defined in the *Key Terms and Definitions* section of this document);
- Not services or supplies that are excluded from coverage (as provided in the Exclusions section).
- Charges for services or supplies that do not exceed the Plan Year maximum benefits as shown in the Schedule of Medical Benefits.

Generally, the Plan will not reimburse you for all eligible medical expenses. Usually, you will have to pay some portion of costs, known as cost-sharing such as Copayments, Deductibles, or Coinsurance toward the amounts you incur that are eligible medical expenses. However, you are only required to pay copayments and coinsurance for eligible medical expenses up to the Plan year individual or family out-of-pocket maximum.

The above is not all inclusive. For more information regarding eligible medical expenses, see the Summary of Medical Benefits, *Schedule of Medical Benefits*, Key Terms and Definitions, Benefit Limitations and Exclusions sections.

Non-Eligible Medical Expenses

Non-eligible medical expenses are expenses that are excluded from the Plan and do not accumulate towards your Deductible and Out-of-Pocket Maximum.

This Plan does not pay benefits equal to all the medical expenses you may incur. You are responsible for paying the full cost of all expenses that are not Eligible Medical Expenses, including expenses that are:

- Not determined to be medically necessary (unless otherwise stated in this Plan).
- Determined to be in excess of the usual and customary charges.
- Determined to be in excess of the Plan's Maximum Allowable Charge.
- Expenses for medical services or supplies that are not covered by the Plan, including but not limited to, expenses that exceed the PPO provider contract rate, excluded benefits as listed in the *Benefit Limitations and Exclusions* section, and dental expenses.
- Benefits exceeding those services or supplies subject to limited overall maximums for each covered individual for certain Eligible Medical Expenses.
- Additional amounts you are required to pay because of a penalty for failure to comply with the Plan's utilization management requirements described in the *Utilization Management* section of this document. If you fail to follow certain requirements of the Plan's utilization management program, the Plan may pay a smaller percentage of the cost of those services, and you may have to pay a greater percentage of those costs. The additional amount you may have to pay is in addition to your Deductible or Out-of-Pocket Maximum.
- Preventive Care/Wellness benefits that are paid by the Plan at 100% do not accumulate towards the Out-of-Pocket Maximum.

This list is not all inclusive and may not include certain services and supplies that are not listed above.

Non-Eligible Medical Expenses do not accumulate toward the Plan Year Deductible or Out-of-Pocket Maximum as determined by the Plan Administrator for your specific coverage tier. You are responsible for paying these expenses out of your own pocket.

For more information regarding Non-Eligible Medical Expenses, see the Benefit Limitations and Exclusions section.

PPO Network Health Care Provider Services

If you receive medical services or supplies from an In-Network PPO provider, you will be responsible for paying less money out-of-pocket. Health care providers who are participating providers of the PPO network have agreed to accept the PPO network negotiated amounts in place of their standard charges for covered services. You are responsible for any applicable Plan

Copayment, Deductible, and or Coinsurance requirements as outlined in this document and are described in more detail in the *Schedule of Medical Benefits*.

With exception of services subject to the No Surprises Act, Out-of-network providers may bill you their standard charges and any balance that may be due after the Plan payment. It is the participant's responsibility to verify the In-Network status of a chosen provider.

NOTE: In accordance with NRS 695G.164, if you are seeing a provider that is In-Network and that provider leaves the network, and you are actively undergoing a medically necessary course of treatment, and you and your provider agree that a disruption to your current care may not be in your best interest or if continuity of care is not possible immediately with another In-Network provider, PEBP will pay that provider at the same level they were being paid while contracted with PEBP's PPO network, if the provider agrees. If the provider agrees to these terms, coverage may continue until:

- The 120th day after the date the contract is terminated; or
- If the medical condition is pregnancy, the 90th day after:
  - The date of delivery; or
  - If the pregnancy does not end in delivery, the date of the end of the pregnancy.

Out-of-Country Medical, Prescription and Vision Purchases

This Plan provides you with coverage worldwide. Whether you reside in the United States and travel to a foreign country, or if you reside outside of the United States permanently or on a part-time basis, and require medical, prescription drug, or vision care services, you may be eligible for reimbursement of the cost.

Please contact this Plan's third-party claims administrator and pharmacy benefit manager before traveling or moving to another country to discuss any criteria that may apply to a medical, prescription drug, or vision service reimbursement request.

Typically, providers in foreign countries do not accept payment directly from the Plan. You may be required to pay for medical and vision care services and submit your receipts to this Plan's third-party claims administrator for possible reimbursement. Medical and vision services received outside of the United States are subject to Plan provisions, coverage, limitations, exclusions, clinical review, if necessary, determination of medical necessity, and the Plan's Maximum Allowable Charge. The review may include regulations determined by the FDA. Out-of-country medication purchases are only eligible for reimbursement while traveling outside of the United States.

The third-party claims administrator may require a written notice from you or your designated representative explaining why you received the medical services from an out of country provider and why you were unable to travel to the United States for these services. This provision applies to elective and emergency services.

Prior to submitting receipts from a foreign country to this Plan's third-party claims administrator, you must complete the following:

- Proof of payment from you to the provider of service (typically your credit card invoice).
- Itemized bill to include complete description of the services rendered and admitting diagnosis(es).
- Itemized bill must be translated to English.
- Reimbursement request converted to United States dollars.
- Foreign purchases of medical care and services are subject to Plan limitations such as:
  - Benefit coverage
  - Coinsurance and deductibles
  - Frequency maximums
  - Annual benefit maximums
  - Medical necessity
  - FDA approval
  - Usual and Customary or this Plan's Maximum Allowable Charge

The Plan Administrator and the third-party claims administrator reserve the right to request additional information. If the provider will accept payment directly from the third-party claim's administrator, you must also provide the following:

- Assignment of benefits signed by you or an individual with the authority to sign on your behalf such as a legal guardian or Power of Attorney (POA).

Once payment is made to you or to the out-of-country provider, the Plan Administrator and its vendors are released from any further liability for the out-of-country claim. The Plan Administrator has the exclusive authority to determine the eligibility of all medical services rendered by an out-of-country provider. The Plan Administrator may or may not authorize payment to you or to the out-of-country provider if all requirements of these provisions are not satisfied.

This Plan may provide certain benefits for travel assistance back to the United States.

This Plan may provide benefits for the purposes of emergency medical transportation only. For more information, contact this Plan's third-party claims administrator listed in the *Participant Contact Guide*.

Health Reimbursement Arrangement

PEBP and its vendor require direct deposit for HRA reimbursements.

Active Employees

This section provides summary information only. For more detailed information regarding this important benefit, see Internal Revenue Service (IRS) Publication 502 or contact the HRA third-party claims administrator listed in the *Participant Contact Guide*.

PEBP will be funding an HRA for active employees enrolled in a qualifying PEBP plan for Plan Year 2024~~in this Plan on July 1, 2023~~. **This is a one-time event.**

Funds in the HRA account may be used to pay for qualified medical expenses as defined by the IRS (see IRS Publication 502), other than premiums, including payment of Deductibles, Coinsurance, and other Out-of-Pocket qualifying healthcare expenses not covered by this Plan.

The HRA may only be used to pay or reimburse qualified Out-of-Pocket health care expenses incurred by the following individuals enrolled in this Plan (or other non-HRA group health coverage providing minimum value):

- the participant; or
- the participant's spouse; or
- participant's dependent(s) who could be claimed on the participant's annual tax return.

HRA funds may not be used for a person who does not meet the IRS definition of a qualified tax dependent, including many domestic partners, children of domestic partners and older children who cannot be claimed on the participant's tax return, regardless of whether PEBP provides coverage for the dependent.

The entire annual PEBP one-time contribution for **Plan Year 2024** will be available for use at the beginning of the Plan Year on or about **July 1, 2023** (subject to certain limitations). Participants who initially elect PEBP coverage after July 1, 2023, will receive a pro-rated base contribution for the participant based upon the coverage effective date and the months remaining in the Plan Year. Participants cannot contribute to an HRA. If the annual funds in the HRA are exhausted, neither PEBP nor the participant will contribute any additional funds.

Any funds remaining in the HRA at the end of the Plan Year will carryover (i.e., will not be forfeited) and will be available for use in the following Plan Year as long as the member maintains the same Plan.

Participants are allowed the option annually, and at termination in the plan, to permanently opt-out of the HRA, and thereby forfeit any unused balance.

Unlike a Flexible Spending Account (FSA), participants cannot be reimbursed from funds that are not yet available in the HRA. Any reimbursement from the HRA will be the lesser of the available HRA balance or the claim amount paid to the provider.

HRA funds are not portable between different plan types; participants cannot use HRA funds if they are no longer covered by the initial Plan with an HRA. If a participant terminates their coverage, the remaining balance in the HRA account will revert to PEBP, unless the qualified beneficiary elects COBRA. Participants enrolled with an HRA who change plans during the Open Enrollment period or during a Qualifying Life Event to a plan with an HSA and retirees who transition coverage to the Medicare Exchange will forfeit any remaining funds in the HRA account.

Active employees who retire and who are not Medicare age (typically at age 65 years) can maintain the balance of their HRA account at retirement if:

- They are eligible to enroll in and continue coverage under a PEBP plan; or
- Continue coverage under COBRA.
    - If a participant elects COBRA coverage, the HRA account will remain in place until COBRA coverage is terminated.

In the case of a retroactive coverage termination, any funds used from the HRA for expenses that are incurred after the date of coverage termination will be recovered by PEBP through the collection process.

Retirees who have a HRA balance and who transition to the Medicare Exchange will forfeit any remaining funds in the HRA on the last day of coverage under this Plan.

The death of an active employee or retiree will cause any remaining funds in the HRA to be forfeited on the first day following the date of death.

Timely Filing of HRA Claims

In accordance with NAC 287.610, all claim requests must be submitted to the third-party claims administrator within one year (12 months) from the date of service that the claim is incurred. No plan benefits will be paid for any claim requests submitted after this period.

When your HRA-eligible coverage ends, you will have one year (12-months) from the date your coverage ends to file a claim for reimbursement from your HRA for eligible claims incurred during your coverage period in accordance with NAC 287.610. HRA funds may not be used to pay premiums.

HRA Contributions for Eligible Active Employees and Retirees	
Employee	**One-Time Contribution**
Participant Only	***$300**

*HRA contribution provided to eligible active employees enrolled in this Plan on **July 1, 2023**. For **Plan Year 2024**, dependents are not eligible for PEBP HRA contributions.

Under no circumstances will a participant who received contributions during the Plan Year be eligible for additional contributions due to reinstatement of coverage or changing plans.

Utilization Management

The Plan is designed to provide you and your eligible dependents with financial protection from significant health care expenses. To enable the Plan to provide coverage in a cost-effective way, it has a Utilization Management (UM) program designed to help control increasing health care costs by avoiding unnecessary services, directing participants to more cost-effective treatments capable of achieving the same or better results and managing new medical technology and procedures. If you follow the procedures of the Plan's UM program, you may avoid some Out-of-Pocket costs. However, if you do not follow these procedures, Plan benefits may be reduced, and you will be responsible for paying more out of pocket.

The Plan's UM program is administered by an independent professional UM company operating under a contract with the Plan. The name, address and telephone number of UM company appears in the *Participant Contact Guide* section. The health care professionals at the UM company focus their review on the medical necessity of hospital stays and the medical necessity, appropriateness, and cost-effectiveness of proposed medical or surgical services. In carrying out its responsibilities under the Plan, the UM company has been given discretionary authority by the Plan administrator to determine if a course of care or treatment is medically necessary with respect to the patient's condition and within the terms and provisions of the Plan.

The UM program is not intended to diagnose or treat medical conditions, validate eligibility for coverage, or guarantee payment of Plan benefits. Eligibility for and actual payment of benefits are subject to the terms and conditions of the Plan as described in this document, PEBP's *Employee Health and Welfare Wrap Plan, and Retiree Health and Welfare Wrap Plan* documents. For example, benefits would not be payable if your eligibility for coverage ended before the services were rendered, or if the services were not covered, either in whole or in part, by an exclusion in the Plan.

Regardless of whether your physician recommends surgery, hospitalization, confinement in a skilled nursing or sub-acute facility, or your physician or other provider proposes or provides any medical service or supply does not mean the recommended services or supplies will be considered medically necessary for determining coverage under the Plan.

Benefits payable by the Plan may be affected by the determination of the UM company if:

- the UM company does not authorize a proposed surgery or other proposed medical treatment as medically necessary; or
- The Plan will not pay regular benefits for a hospitalization or confinement in a skilled nursing or sub-acute facility because the UM company does not authorize a proposed confinement.

PEBP, the third-party claim administrator, and the UM company are not engaged in the practice of medicine and are not responsible for the outcomes of health care services rendered (even if the health care services have been authorized by the UM company as medically necessary), or

for the outcomes if the patient chooses not to receive health care services that have not been authorized by the UM company as medically necessary.

When reviewing services for appropriateness of care and medical necessity, the UM company uses guidelines and criteria published by nationally recognized organizations, along with medical judgement of licensed heath care professionals.

Delivery of Services

You are entitled to receive medically necessary medical care and services as specified in this Plan's *Summary of Medical Benefits* and *Schedule of Medical Benefits*. These include medical, mental health, behavioral health, surgical, diagnostic, therapeutic, and preventive services. If a precertification is required and you do not obtain the required precertification, the service may not be covered, even if the service is medically necessary. These services, although not all inclusive are those that generally:

- Are provided In-Network and Out-of-Network,
- Are performed or ordered by a participating provider,
- Require a precertification according to the utilization management and quality assurance protocols, if applicable.

Concurrent Review

Concurrent Review (continued stay) is the ongoing assessment of the health care as it is being provided, especially (but not limited to) inpatient confinement in a hospital or skilled nursing or sub-acute facility. When you are receiving medical services in a hospital or other inpatient facility, the UM company monitors your stay by contacting your physician or other providers to assure that continuation of medical services in the facility is medically necessary. The UM company will also help coordinate your medical care with other healthcare benefits available under the Plan.

Concurrent review may include such services as coordinating home health care or durable medical equipment, assisting with discharge plans, determining the need for continued medical services, and or advising your physician or other providers of various options and alternatives for your medical care available under this Plan.

If at any point, your stay is found not to be medically necessary and care could be safely and effectively delivered in another environment (such as through home health care or in another type of health care facility), you and your physician will be notified. This does not mean that you must leave the hospital, but if you choose to stay, all expenses incurred after the notification will be your responsibility. If your hospital stay is determined not to be medically necessary, no benefits will be paid on any related hospital, medical or surgical expense. You may also appeal the determination (refer to the *Appealing a UM determination* section).

Retrospective Review

Retrospective Review is the review of health care services after they have been provided to determine if those services were medically necessary. The Plan will pay benefits only for those

days or treatments that would have been authorized under the utilization management program; and case management: The process whereby the patient, the patient's family, physician, or other providers work together with the Plan Administrator or its designee under the guidance of the UM company to coordinate a quality, timely and cost-effective treatment plan.

Case Management

Case management is a voluntary process administered by the UM company. Its medical professionals work with the patient, the patient's family, caregivers, providers, the third-party claims administrator, and the Plan Administrator or its designee to coordinate a timely and cost-effective treatment program. Case management services are particularly helpful when the patient needs complex, costly and/or high-technology services, or when assistance is needed to guide the patient through a maze of potential providers. Case management is available for individuals diagnosed with sickle cell or its variants, among other conditions (NRS 695G.174).

The case manager will work directly with your physician, hospital, and/or other provider to review proposed treatment plans and to assist in coordinating services and obtaining discounts from providers as needed. From time to time, the case manager may confer with your physician or other providers and may contact you or your family to assist in making plans for continued health care services or obtaining information to facilitate those services.

You, your family, or your physician may call the case manager at any time to ask questions, make suggestions or offer information. The case manager can be reached by calling the UM company at the telephone number shown in the *Participant Contact Guide* section or on the PEBP website at www.pebp.state.nv.us.

Precertification (Prior Authorization) Process

Precertification prior authorization review is a procedure administered by the UM company to assure health care services meet or exceed accepted standards of care. In certain cases, as set forth below, for a benefit to be covered, the UM company must approve and/or pre-certify the service**. If a precertification is required and you do not obtain the required precertification, benefits may be reduced, even if the service is medically necessary.** The UM company uses nationally recognized guidelines and criteria as standard measurement tools to determine whether benefits are approved and/or pre-certified.

Precertification also includes the determination of whether the admission and length of stay in a hospital or skilled nursing or sub-acute facility, surgery or other health care services are medically necessary and if the location of service is high quality and lowest cost.

A precertification is required for referrals to physicians and providers for certain services. All benefits listed in this Plan may be subject to precertification requirements and concurrent or retrospective review depending upon the circumstances associated with the services. Refer to the Services Requiring Precertification section below for more information.

Failure to obtain precertification may result in your benefits being reduced or denied (see the Failure to Follow Required Utilization Management Procedures in this section).

Services Requiring Precertification (Prior Authorization)

All Inpatient Admissions

- Acute; observation; and same day surgeries
- Long-Term Acute Care
- Rehabilitation
- Behavioral Health
- Transplant including all pre-transplant related expenses
- Skilled Nursing facility and sub-acute facility
- Residential Treatment Facility, including outpatient partial hospitalization programs, and partial residential treatment programs
- Hospice (inpatient/outpatient) exceeding 185 days
- Obstetric – (precertification only required if days exceed 48 hours for vaginal delivery or 96 hours for a C-section)
- Intraoperative Neuro Monitoring

Outpatient and Physician - Surgery

- Back Surgeries and hardware related to surgery
- Total and remaining Hip and Knee Surgeries
- Biopsies (excluding skin, colonoscopy and upper GI endoscopy biopsy, upper GI endoscopy diagnosis)
- Thyroidectomy, Partial or Complete
- Open Prostatectomy
- Oophorectomy, unilateral and bilateral
- Hysterectomy (including prophylactic)
- Autologous chondrocyte implantation, Carticel
- Transplant (excluding cornea)
- Balloon sinuplasty
- Surgeries to treat Gender Dysphoria
- Bariatric/weight loss surgeries at Centers of Excellence and adjustments to lap bands after the first 12 months post-surgery
- Sleep apnea related surgeries, limited to:
    - Radiofrequency ablation (Coblation, Somnoplasty)
    - Uvulopalatopharyngoplasty (UPPP) (including laser-assisted procedures)
- Mastectomy (including gynecomastia and prophylactic) and reconstruction surgery
- Orthognathic procedures (e.g., Genioplasty, LeFort osteotomy, Mandibular ORIF, TMJ)
- Varicose vein surgery/sclerotherapy
- Any procedure deemed to be Experimental and/or Investigational (provider must indicate on the pre-certification request that the service/procedure is Experimental and/or Investigational and/or part of a clinical trial)

- Intraoperative Neuro Monitoring

- Prophylactic surgery

Outpatient and Physician – Diagnostic Services

- CT, PET, SPEC, and MRI
- Capsule endoscopy
- Genetic Testing (including BRCA)

Outpatient and Physician – Continuing Care Services

- Applied Behavior Analysis (ABA) Therapy
- Dialysis
- Electroconvulsive Therapy (ECT)
- Chemotherapy
    - Oral Chemotherapy to be reviewed by Pharmacy Benefit Manager
- Radiation Therapy
- Oncology and transplant related injections, infusions, and treatments (e.g., CAR-T, endocrine and immunotherapy), excluding supportive drugs (e.g., antiemetic and antihistamine)
- Hyperbaric Oxygen
- Home Health Care
- Electroconvulsive Therapy (ECT)
- Transcranial Magnetic Stimulation (TMS)
- Durable Medical Equipment exceeding $1,000
    - Prior authorization is based on overall cost to the plan and/or purchase price, not the amount billed for monthly rental. DME rental to purchase in accordance with Medicare guidelines.
- Non-Emergency Medical Transportation – scheduled air and ground facility to facility and interstate
- Injectables and infusions excluding services reviewed by the PBM
- Behavioral Health Intensive Outpatient programs
- Sickle Cell Disease
- Vein Therapy
- Habilitative and rehabilitative therapy (physical, speech, occupational) exceeding a combined visit limit of 90 visits per Plan Year

Services Not Requiring Precertification (Prior Authorization)

Prior authorization is not required for medically necessary emergency services when a medical condition that manifests itself by symptoms of such severity (including severe pain) that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect that the absence of immediate medical attention could result in:

- Serious jeopardy to the health of the participant.
- Serious jeopardy to the health of an unborn child.
- Serious impairment of a bodily function; or

- Serious dysfunction of any bodily organ or part.

The UM company must be notified of an emergency hospital admission within one business day so the UM company can conduct a *concurrent review*. Your physician or the hospital should call the UM company to initiate the concurrent review. Even though a precertification may not be required for some services, the hospital or facility is still required to comply with the Plan's provisions regarding UM, such as concurrent review.

How to Request Precertification (Prior Authorization)

It is your responsibility to ensure that precertification occurs when it is required by the Plan. Any penalty or denial of benefits for failure to obtain precertification is your responsibility, not the provider's. You or your physician must call the UM company at the telephone number shown in the ***Participant Contact Guide*** to request precertification. Calls for elective services should be made at least 15 calendar days before the expected date of service or may be subject to the benefit reduction listed in the ***Utilization Management*** section. The UM company will require the following information:

- The employer's name.
- Employee's name.
- Patient's name, address, phone number and Social Security Number or PEBP unique ID.
- Physician's name, phone number or address.
- The name of any hospital or outpatient facility or any other provider that will be providing services.
- The reason for the health care services or supplies; and
- The proposed date for performing the services or providing the supplies.

The UM company will review the information and provide a determination to you, your physician, the hospital or other provider, and the third-party claims administrator as to whether the proposed health care services have been determined to be medically necessary. Additionally, the UM company may approve medical necessity but not site of care. In these circumstances, the UM company will provide approved alternate locations to the caller. While industry and accreditation standards require a preauthorization determination within 15 calendar days for a non-urgent case, the UM company will usually respond to your physician or other provider by telephone within (5) five business days of receipt of the request. The determination will then be confirmed in writing.

If your hospital admission or medical service is determined not to be medically necessary, you and your physician will be given recommendations for alternative treatment. You may also pursue an appeal (refer to the *Appealing a UM Determination* section).

Second Opinion

The utilization management company may authorize a second opinion upon your request in accordance with this Plan. Examples of instances where a second opinion may be appropriate include:

- Your physician has recommended a procedure and you are unsure whether the procedure is necessary or reasonable.
- You have questions about a diagnosis or plan or care for a condition that threatens substantial impairment or loss of life, or bodily functions.
- You are unclear about the clinical indications about your condition.
- A diagnosis is in doubt due to conflicting test results.
- Your physician is unable to diagnose your condition; and a treatment plan in progress is not improving your medical condition within a reasonable period.

A participating provider, including your primary care physician, may notify the UM company on your behalf to obtain precertification (prior authorization) for the services described in Services Requiring Precertification (Prior Authorization)

Hospital Admission

You are responsible for ensuring the UM company is notified at least 5 (five) business days before an inpatient admission to obtain pre-certification.

Your physician or other provider may notify the UM company, but it is ultimately your responsibility to make sure they are notified. The UM company will review the physician/provider's recommendation and treatment plan to determine the level of care and place of service. If the UM company denies the precertification for hospital admission as not covered or they determine that the services do not meet the UM company's medical necessity criteria, the Plan's third-party administrator will only pay benefits for inpatient that has been pre-certified.

You are required to obtain a precertification before you obtain services for inpatient elective surgeries. If you do not follow the required UM process, benefits for the elective surgeries may be reduced by 50% of this Plan's Maximum Allowable Charge. This provision applies to both In-Network and Out-of-Network surgery expenses. Expenses related to the penalty will not be counted to meet your Out-of-Pocket Maximum, if applicable.

Emergency and Urgent Hospital Admission

This includes all complications of pregnancy.

You are not required to obtain a precertification before you obtain services for a medical emergency. However, the UM company must still be notified within 24 hours, the next business day, or as soon as reasonable after admission so the UM company can conduct a concurrent review. If you are incapacitated and you (or a friend or relative) cannot notify the UM company within the above stated times, they must receive notification as soon as reasonably possible after the admission or you may be subject to reduction or denial of benefits as provided by the Plan.

- Emergency Hospital Admission: Admission for hospital confinement that results from a sudden and unexpected onset of a condition that requires medical or surgical care. In the absence of such care, you could reasonably be expected to suffer serious bodily injury or death. Examples of emergency hospital admission include, but are not limited to, admissions, for heart attacks, severe chest pain, burns, loss of consciousness, serious breathing difficulties, spinal injuries, and other acute conditions.
- An urgent hospital admission means an admission for a medical condition resulting from injury or serious illness that is less severe than an emergency hospital admission but requires care within a short time, including complications of pregnancy.

Even though a precertification may not be required for some services, the hospital or facility is still required to comply with the Plan's provisions regarding utilization management, such as concurrent review.

If you do not follow the required UM process, benefits payable for the services may be reduced by 50% of this Plan's Maximum Allowable Charge. This provision applies to both In-Network and Out-of-Network medical expenses. Expenses related to the penalty will not be counted to meet your Out-of-Pocket Maximum.

Confinement in an Out-of-Network Hospital Following an Emergency Admission

Please refer to the No Surprises Act section of this document for claims subject to that Act. For all other confinements, if you are confined in an Out-of-Network hospital after you receive emergency services, the UM company must be notified within 24 hours, the next business day, or as soon as reasonable after admission. The UM company may determine it is appropriate to transfer you to an In-Network hospital as soon as it is medically appropriate to do so. If you choose to stay in the Out-of-Network hospital after the date the UM company decides a transfer is medically appropriate, the Plan will pay Eligible Medical Expenses at the Out-of-Network benefit level, subject to the Plan's Maximum Allowable Charge if the continued stay is authorized by the UM company and determined to be a covered service.

Other Exceptions

If you receive ancillary services such as an x-ray, laboratory services, or anesthesia services from an Out-of-Network provider while receiving services at an In-Network inpatient or outpatient facility (such as an outpatient surgery center), the Plan will cover the Eligible Medical Expenses at the In-Network benefit level, subject to the Plan's Maximum Allowable Charge.

Elective Knee and Hip Joint Replacement – Nevada Exclusive Hospitals and Outpatient Surgery Centers

Precertification is required; the UM company will review the request based on surgery type, medical necessity, covered benefits, provider quality, cost, and provider location.

Due to cost variations for elective knee and hip joint replacement performed in Nevada, the third-party claims administrator has identified exclusive providers who meet the Plan's cost

threshold for routine knee and hip replacement procedures. The exclusive provider list can be found on the PEBP website.

If you choose a provider on the exclusive list, you will potentially reduce your out-of-pocket costs in accordance with the standard plan benefits.

However, if you choose to use a non-exclusive provider, the Plan will pay benefits in accordance with its cost threshold or Maximum Allowable Charge. You may be subject to balance billing for any amount exceeding this Plan's cost threshold. Amounts exceeding the Plan's established threshold will not apply to your Deductible (if applicable) or Out-of-Pocket Maximum.

Inpatient or Outpatient Surgery

You are responsible for ensuring that the UM company is notified at least 5 (five) business days before elective inpatient or outpatient surgery is performed to ensure that it is covered.

Your physician or other provider may notify the UM company, but it is your responsibility to make sure they are notified. The UM company will review the physician's recommended course of treatment to ensure the requested treatment meets established medical necessity criteria and protocols.

The claims administrator will only pay benefits for inpatient or outpatient surgery that is pre-certified, and the services/supplies are a covered benefit.

Outpatient Infusion Services

Precertification is required for outpatient infusion services. The UM company will review the request based on covered benefits, medical necessity, provider quality, cost, and location. If you choose to receive your infusion at a non-exclusive hospital or infusion center, you will be responsible for any amount that exceeds this Plan's Maximum Allowable Charge. Amounts exceeding this Plan's established cost threshold will not apply to your annual Deductible or Out-of-Pocket Maximum.

Air Ambulance Services

This Plan provides coverage for emergency air ambulance and inter-facility patient air transport if there is a life-threatening situation, or the service is deemed medically necessary by the UM company. The air ambulance services are subject to the Plan Deductible, if applicable, then the Plan will pay the lower of the PPO allowable for In-Network air ambulance providers, or for Out-of-Network providers, the Plan will pay up to the Recognized Amount.

See the Utilization Management section for air ambulance precertification requirements.

Air/Flight Schedule Inter-Facility Transfer

All inter-facility transport services require precertification. The UM company may discuss with the physician and/or hospital/facility the diagnosis and the need for inter-facility patient transport versus alternatives. Failure to obtain a precertification may result in a reduction or

denial of benefits for charges arising from or related to flight-based inter-facility transfers. Non-compliance penalties imposed for failure to obtain a precertification will not be included as part of the annual out-of-pocket maximum.

Inter-facility transport may occur if there is a life-threatening situation, or the transport is deemed medically necessary. The following conditions apply:

Article 1 Services via any form of air/flight for inter-facility transfers must be pre-certified before transport of the participant to another hospital or facility, and the participant is in a hospital or other health care facility under the care or supervision of a licensed health care provider; and

Article 2 Inaccessibility to ground ambulance transport or extended length of time required to transport the patient via ground ambulance transportation could endanger the patient.

Emergency Air Ambulance

This Plan provides coverage for emergency air ambulance transportation for participants whose medical condition at the time of pick-up requires immediate and rapid transport due to the nature and/or severity of the illness/injury. Air ambulance transportation must meet the following criteria:

- Services via any form of air/flight for emergency air ambulance; and
- The patient's destination is an acute care hospital; and
- The patient's condition is such that the ground ambulance (basic or advanced life support) would endanger the patient's life or health; or
- Inaccessibility to ground ambulance transport or extended length of time required to transport the patient via ground ambulance transportation could endanger the patient.

See Air Ambulance Services for details on plan benefits and coverage.

Gender Dysphoria Related Services

The participant or their physician should contact the UM company to begin the process toward surgical intervention of gender dysphoria. The initial contact will include:

- Notification to the participant that the precertification process begins with the initial contact to the UM company.
- Coverage for procedures are based on the UM company's clinical policy for medical necessity. and
- Advising participants of providers who specialize in this type of treatment.

This service is provided by the UM company and will be initiated upon the first call for a precertification. Case management services are particularly helpful for a participant or their covered dependent who is receiving complex medical services for medical conditions such as gender dysphoria. Your assigned case manager nurse will provide you with assistance with

addressing any concerns you may have about issues such as, continuity of care or finding providers or a provider who specializes in gender dysphoria.

Health Care Services and Supplies Review

A participating provider, including your primary care physician, may notify the UM company on your behalf to obtain precertification (prior authorization) for the services described in *Services Requiring Precertification (Prior Authorization).*

Non-participating providers may not know to notify the UM company to obtain precertification for services. In such a case, you must confirm that the UM company pre-certified the service to assure that it is covered.

The Plan will pay for covered health care services and supplies only if authorized as outlined above. The Plan will not pay for any health care services or supplies that are not covered services or do not meet medically necessary criteria and protocols.

Failure to Follow Required UM Procedures

If you do not follow the required precertification review process described in this section, benefits payable for the services you failed to receive a precertification may be reduced by 50% of the Plan's Maximum Allowable Charge. This provision applies to both In-Network and Out-of-Network *Eligible Medical Expenses*. Expenses related to the penalty will not apply to your Plan Year Deductible or Out-of-Pocket Maximum. If you wish to appeal a decision made by the UM company, refer to the *Appealing a UM Determination* section.

Coronavirus (COVID-19) Benefits

Benefit Description

COVID-19 Plan Benefits

Coronavirus Aid, Relief, and Economic Security Act (CARES Act) (see *Key Terms and Definitions*). Benefits apply during the Coronavirus Pandemic unless otherwise mandated by federal or state law, or as stated below in the Explanations and Limitations.

Explanations and Limitations

Coronavirus (COVID-19) Pandemic Benefits

The following benefits will be paid at 100% of the Maximum Allowable Charge, both, In-and Out-of-Network during the national public health emergency period.

- **COVID-19 Diagnostic Testing:** virus/antigen detection (diagnostic) test determines if a person is currently infected with COVID-19. An antibody (serology) test may determine if a person may have been infected with the virus, and according to the FDA, antibody tests should not be used to diagnose current infection.
  - Medically appropriate, FDA-authorized, COVID-19 testing when ordered by a physician or health care professional for purposes of diagnosis or treatment.
  - Diagnostic testing is different than COVID-19 screening/surveillance testing.
- **COVID-19 Related Diagnostic Testing Visit:** COVID-19 testing related visits such as urgent care, emergency room, physician's office, telemedicine, and telehealth visits.
- **COVID-19 Preventive Health Services:** In accordance with the following, the Plan covers qualifying coronavirus disease 2019 (COVID-19) preventive services at 100% of the Plan's Maximum Allowable Charge for In-Network and Out-of-Network providers without any cost sharing (Copayment, Deductible, or Coinsurance):
  - An evidence-based item or service that has in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; or (B) An immunization that has in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC).

- **Laboratory Services Related to Covid-19**
  - COVID-19 Diagnostic Testing: virus/antigen detection (diagnostic) test determines if a person is currently infected with COVID-19. An antibody (serology) test may determine if a person may have been infected with the virus, and according to the FDA, antibody tests should not be used to diagnose current infection. Covid-19 Diagnostic Testing will be paid at 100% of the Maximum Allowable Charge, both, In-and Out-of-Network in accordance with the CARES Act or until the last date of the national public health emergency period.
  - COVID-19 Screening/Surveillance Testing: COVID testing conducted for purposes other than diagnostic (including, but not limited to, employer mandated, travel, social/entertainment purposes) is not a covered benefit.

All benefits are subject to cost-sharing unless otherwise stated.

Summary of Medical Benefits

To determine the benefit limitations for any health care service or supply, review the Summary and Schedule of Medical Benefits listed below.

To determine precertification requirements, refer to the Utilization Management section.

Copay applies to Primary Care Physician (PCP) and Specialist office visits for evaluation and management services only; imaging, surgery, and other services provided during a PCP or Specialist office visit are subject to the Plan Year Deductible and Coinsurance.

Benefit Description	In-Network	Out-of-Network
Physician Office Visits		
Primary Care Physician (PCP) Office Visit	$30 Copay	Plan pays 50% after Deductible
Specialist Services (including Allergy Services)	$50 Copay	Plan pays 50% after Deductible
No referral is required for these visits. Imaging, surgery, and all other services provided in an office setting subject to Deductible and Coinsurance.		

Benefit Description	In-Network	Out-of-Network
ACA Wellness/Preventive Office Visits and Preventive Screenings The Plan covers recommended preventive care services without participant cost-sharing when services are received by In-Network providers. For more details see *Preventive Services* in the ***Summary of Medical Benefits.***		
Primary Care Wellness Visit	$0 Copay	Not Covered
Obstetrics and Gynecology ACA Services	$0 Copay	Not Covered
Prenatal and Postnatal Office Visit	$0 Copay	Not Covered
No referral is required for these visits. Imaging, surgery, and all other services provided in an office setting subject to Deductible and Coinsurance		

Benefit Description	In-Network	Out-of-Network
Wellness/Preventive Office Visits and Preventive Screenings		
Mammography screening	$0 Copay	Not Covered
Limit: One 2D or 3D mammogram screening per Plan Year for women aged 40 years and older.		
Papanicolaou (Pap) test	$0 Copay	Not Covered
Prostate Specific Antigen (PSA) screening	$0 Copay	Not Covered
Colorectal screening	$0 Copay	Not Covered
Colorectal Screening: Starting at age 45 in accordance with the American Cancer Society's screening guidelines.		
Counseling for sexually transmitted infections (STI), HIV counseling and testing	$0 Copay	Not Covered
Breastfeeding support, supplies, and counseling	$0 Copay	Not Covered
*Contact the third-party claims administrator for the purchase of covered breast pumps. Rental for heavy duty electrical (hospital grade) covered only when medically necessary and only during the newborn's inpatient hospital stay***.**		
Screening for interpersonal and domestic violence	$0 Copay	Not Covered
Contraceptives/In-office counseling	$0 Copay	Not Covered
FDA approved injections, implants, and contraceptive devices not covered under the pharmacy benefits.		
Screening for Gestational Diabetes	$0 Copay	Not Covered
Real Appeal	$0 Copay	Not Covered
High-risk Human Papillomavirus (HPV) testing	$0 Copay	Not Covered
For more information, refer to the Preventive Services in the Schedule of Medical Benefits section. An office visit copay may apply if services provided during the visit include additional services that are not preventive services.		

Benefit Description	In-Network	Out-of-Network
Hospital Facility Services		
Inpatient Hospital Admission	Plan pays 80% after Deductible	Plan pays 50% after Deductible
Inpatient Delivery Postpartum/Newborn Care Services	Plan pays 80% after Deductible	Plan pays 50% after Deductible
Outpatient Observation	$500 Copay	Plan pays 50% after Deductible
Outpatient Observation period lasting more than 23 hours will be considered and paid as an inpatient confinement.		
Outpatient Surgery	$500 Copay	Plan pays 50% after Deductible
Other services, related to and during the outpatient surgery on that date, are not subject to the deductible and coinsurance.		
Skilled Nursing Facility Limit: 100 days per Plan Year	Plan pays 80% after Deductible	Plan pays 50% after Deductible
Rehabilitation, Habilitation Facility (Limited to 60 days per Plan Year)	Plan pays 80% after Deductible	Plan pays 50% after Deductible
*All hospital facility services require precertification. In emergencies in which a member is admitted to hospital for an inpatient stay, the UM company must be notified with 24 hours, the next business day following the admission. *See the Utilization Management section for precertification requirements, including emergency hospital admissions.*		

Benefit Description	In-Network	Out-of-Network
Urgent Care and Emergency Services		
Urgent Care Services*	$80 Copay	$80 Copay, subject to the Plan's Maximum Allowable Charge
Emergency Room Services**	$750 Copay	$750 Copay *
When using Out-of-Network urgent care services, you are responsible for paying this Plan's copayment amount, plus any amounts exceeding the Plan's Maximum Allowable Charge. See Key Terms and Definitions for more information.		
***Emergency Room services: If admitted to the hospital, the ER Copay is waived and the Inpatient Hospital Copay applies.*		

Urgent and Emergency Services		
Ambulance (ground/water)*	Plan pays 80% after Deductible	Plan pays 80% after Deductible, subject to the Maximum Allowable Charge
Ambulance (air)	Plan pays 80% after Deductible	Plan Pays 80% after Deductible *
When using Out-of-Network ambulance providers you are responsible for paying your Deductible and Coinsurance. See the Utilization Management and Schedule of Medical Benefits.* ***see also NRS 695G.170 for medically necessary emergency services at any hospital in Nevada.		

Benefit Description	In-Network	Out-of-Network
Outpatient Specialty Imaging and Diagnostic Testing		
Computer Tomography (CT) Scan	Plan pays 80% after Deductible	Plan pays 50% after Deductible
Positron Emission Tomography (PET) Scan	Plan pays 80% after Deductible	Plan pays 50% after Deductible
Magnetic Resonance Imaging (MRI/MRA)	Plan pays 80% after Deductible	Plan pays 50% after Deductible
Nuclear Medicine	Plan pays 80% after Deductible	Plan pays 50% after Deductible
Angiogram and Myelogram	Plan pays 80% after Deductible	Plan pays 50% after Deductible
Outpatient Specialty Imaging and Diagnostic testing: When performed Out-of-Network, you are responsible for the Plan's cost-share and any amount exceeding the Plan's Maximum Allowable Charge. See the Utilization Management section for precertification requirements.		

Benefit Description	In-Network	Out-of-Network
Non-Specialty Imaging and Diagnostic Testing (Including X-rays and Ultrasounds; except Specialty Imaging and Diagnostic Testing)		
Services provided in a Primary Care Physician Office	Plan pays 80% after Deductible	Plan pays 50% after Deductible
Services provided in a Specialty Care Physician's Office	Plan pays 80% after Deductible	Plan pays 50% after Deductible
Services provided in a hospital outpatient setting	Plan pays 80% after Deductible	Plan pays 50% after Deductible
Diagnostic Mammography	Plan pays 80% after Deductible	Plan pays 50% after Deductible
Non-Specialty Imaging and Diagnostic testing: When performed Out-of-Network, you are responsible for the Plan's cost-share and amounts exceeding the Plan's Maximum Allowable Charge.		

Benefit Description	In-Network	Out-of-Network
Laboratory Outpatient Services		
General Laboratory Services	Plan pays 80% after Deductible	Plan pays 50% after Deductible
Routine/Preventive Lab Testing*	Plan pays 80% after Deductible	Plan pays 50% after Deductible
Routine and Preventive Lab Services **** Routine/preventive lab services must be performed at a freestanding, non-hospital-based lab facility.*** • *Medically necessary routine labs when ordered by a physician as part of comprehensive medical care.* • *Preventive laboratory services such as basic metabolic panel, lipid, or general health panel.* • *Routine/preventive lab tests performed at an outpatient hospital or hospital-based free-standing lab facility/draw station are not covered.*		
Pre-admission Lab Testing Services**	Plan pays 80% after Deductible	Plan pays 50% after Deductible

Pre-Admission Lab Testing Services		
***Pre-admission lab testing performed on an outpatient basis at a hospital-based lab or free-standing hospital-based lab draw station within 7 days prior to a scheduled hospital admission or outpatient surgery. Testing must be related to the sickness or injury for which admission or surgery is planned.*		
Outpatient Short-Term Rehabilitation Services Outpatient Speech, Occupational, and Physical Therapy		
Speech Therapy	$50 Copay per Visit	Plan pays 50% after Deductible
Occupational Therapy	$50 Copay per Visit	Plan pays 50% after Deductible
Physical Therapy	$50 Copay per Visit	Plan pays 50% after Deductible
Precertification required; speech, occupational, and physical therapy visits are limited to a combined 90 visits per Plan Year.		

Benefit Description	In-Network	Out-of-Network
Other Outpatient Therapy and Rehabilitation Services		
Cardiac and Pulmonary rehabilitation	Plan pays 80% after Deductible	Plan pays 50% after Deductible
Limited to medically necessary services; 60 visits per Plan Year for all modalities combined.		
Dialysis	Plan pays 80% after Deductible	Plan pays 50% after Deductible
Wound Therapy	Plan pays 80% after Deductible	Plan pays 50% after Deductible
Chemotherapy Treatment	Plan pays 80% after Deductible	Plan pays 50% after Deductible
Radiation therapy (Outpatient hospital/facility, or physician's office)	Plan pays 80% after Deductible	Plan pays 50% after Deductible
Infusion Therapy (home/outpatient, including specialty drugs)	Plan pays 70% after Deductible	Plan pays 50% after Deductible
See the Utilization Management section for all precertification requirements.		

Benefit Description	In-Network	Out-of-Network
Surgical Services		
Performed in a Primary Care Physician's office	Plan pays 80% after Deductible	Plan pays 50% after Deductible
Performed in a Specialty Care Physician's office	Plan pays 80% after Deductible	Plan pays 50% after Deductible
Performed in same-day surgery facility or Ambulatory Surgery Center (ASC)	$500 Copay	Plan pays 50% after Deductible
See the Utilization Management section for surgical services requiring precertification.		

Benefit Description	In-Network	Out-of-Network
Medical Supplies, Equipment, and Prosthetics		
Durable Medical Equipment	Plan pays 80% after Deductible	Plan pays 50% after Deductible
Durable Medical Equipment (DME): Limited to one purchase, repair, or replacement of a specific item of DME every 3 years. DME rental to purchase in accordance with Medicare guidelines. The purchase or rental of DME, including oxygen related equipment in excess of $1,000 requires precertification.		
Orthopedic and prosthetic devices	Plan pays 80% after Deductible	Plan pays 50% after Deductible
Orthopedic and prosthetic devices: Limited to a single purchase of a type of prosthetic device, including repair and replacement, every 3 years. Orthopedic and prosthetic devices in excess of $1,000 require precertification.		
Hearing Aids	$50 Copay per Device	$50 Copay per Device
Hearing Aids: Coverage for medically necessary, FDA approved air conduction hearing aids. Subject to a $50 Copay per device, Maximum benefit $1,500 per device, per each ear, every 3 years.		
Special Food Product	Plan pays 80% after Deductible	Plan pays 50% after Deductible
*Special Food Product: $2,500 maximum benefit per Plan Year for Special Food Products for the treatment of a person with inherited metabolic diseases. See **Enteral Formulas and Special Food Products** in the Schedule of Medical Benefits.*		
Enteral Formula	Plan pays 80% after Deductible	Plan pays 50% after Deductible

*Enteral Formula for the treatment of inherited metabolic disease. See **Enteral Formulas and Special Food Products** in the Schedule of Medical Benefits.*

Mental/Behavioral Health Treatment		
Inpatient/Residential Rehabilitation	Plan pays 80% after Deductible	Plan pays 50% after Deductible
Intensive Outpatient Treatment Program	$30 Copay per Visit	Plan pays 50% after Deductible
Partial Hospitalization Program	Plan pays 80% after Deductible	Plan pays 50% after Deductible
Applied Behavioral Therapy	$30 Copay per Visit	Plan pays 50% after Deductible
Outpatient treatment	$30 Copay per Visit	Plan pays 50% after Deductible
Psychological testing	Plan pays 80% after Deductible	Plan pays 50% after Deductible
Refer to the Utilization Management section for precertification requirements.		

Benefit Description	In-Network	Out-of-Network
Other Medical Services – Doctor on Demand, Telehealth, 2nd.MD		
	Doctor on Demand Telemedicine Visit	
Medical Visit	$10 Copay per Visit	Not Covered
Psychology Visit (25-minutes)	$20 Copay per Visit	Not Covered
Psychologist Visit (50 -minutes)	$30 Copay per Visit	Not Covered
Psychiatrist Visit (45 minutes/initial visit)	$30 Copay per Visit	Not Covered
Psychiatry Visit	$20 Copay per Visit	Not Covered

(15-minute follow-up visit)		
Telehealth Visit		
Primary Care Visit	$30 Copay per Visit	Plan pays 50% after Deductible
Specialist Care Visit	$50 Copay per Visit	Plan pays 50% after Deductible
2nd.MD (Second Opinion Services)		
2nd.MD (Second Opinion Services)	$0 Copay per Visit	Not Covered

Benefit Description	In-Network	Out-of-Network
Other Medical Services		
Chiropractic (Spinal manipulation services)	$50 Copay per Visit	Plan pays 50% after Deductible
Chiropractic and spinal manipulation services: Limited to 20 office visits per Plan Year.		
Acupuncture, Acupressure services	$50 Copay per Visit	Plan pays 50% after Deductible
Acupuncture and acupressure services: Limited to 20 visits (combined) per Plan Year, 100 visits (combined) per lifetime.		

Benefit Description	In-Network	Out-of-Network
Other Medical Services		
Home Health Care	Plan pays 80% after Deductible	Plan pays 50% after Deductible
Home Health Care: Limited to 60 visits per Plan year; may provide for private duty nursing in the home; requires precertification. Additional visits are subject to preauthorization by the UM company.		
Office-based infertility services	Plan pays 80% after Deductible	Plan pays 50% after Deductible

Medically necessary services for subscriber, spouse, and/or domestic partner to diagnose problems of infertility for a covered individual (limited to one diagnostic evaluation for infertility every Plan Year, and up to three (3) per lifetime~~, and up to six (6) artificial inseminations per lifetime~~. See exclusions in the Benefit Limitations and Exclusions. These limits and exclusions apply to both office-based and non-office-based infertility services. For cost sharing for infertility services that are not performed in the office, see the applicable section in the Summary of Medical Benefits		
Temporomandibular Joint (TMJ) Disorder Services*		
Office-based services (excluding surgical services)	**Specialist Visit:** $50 Copay **Other office-based services:** Plan pays 80% after Deductible	Plan pays 50% after Deductible
TMJ Surgical Services (including surgical services)	**Outpatient Surgery:** $500 Copay **Inpatient:** Plan pays 80% after Deductible	Plan pays 50% after Deductible
TMJ disorder and dysfunction services and supplies including night guards are covered only when the required services are not recognized dental procedures. Limited to two (2) surgeries in a lifetime.		

Benefit Description	In-Network	Out-of-Network
Other Medical Services		
Hospice	Plan pays 80% after Deductible	Plan pays 50% after Deductible
The hospice care program administers palliative and supportive health care services providing physical, psychological, social, and spiritual care for terminally ill patients with a life expectancy of 6 months or less as certified by patient's medical physician. For outpatient bereavement counseling services, see Hospice Services in the Schedule of Medical Benefits. Precertification is required for both inpatient and outpatient hospice services exceeding 185 days. *For a description of the hospice care benefits, see Hospice Services in the Schedule of Medical Benefits.*		

Benefit Description	In-Network	Out-of-Network
Obesity Care Management (OCM) Program (Disease Management Program)		

Weight Loss Medication	*Preferred -Retail 30-Day Supply	Home Delivery 90-Day Supply*	
Preferred/Formulary Generic	$0 Copay	$0 Copay	Not Covered
Preferred/Formulary Brand	$20 Copay	$40 Copay	Not Covered
Non-Preferred/Non-Formulary Brand	$75 Copay	$150 Copay	Not Covered

*__Preferred Retail Network__ *Pharmacies: Copayments apply if you fill your prescription at a* __Preferred Retail Network__ *retail pharmacy. If you fill your prescription at a non-*__Preferred Retail Network__ *retail pharmacy, you will pay an additional $10 per prescription. If you currently use a non-*__Preferred Retail Network__ *pharmacy and you want to avoid the $10 upcharge, call a* __Preferred Retail Network__ *pharmacy to transfer your prescription. See the Schedule of Pharmacy Benefits for instructions on how to find a* __Preferred Retail Network__ *pharmacy. Certain weight loss medications may not be available in 90-day supply. Contact Express Scripts for information about your prescribed medication.*

* Retail 90-day Supply is three (3) times the copay for the 30-day supply

Benefit Description	In-Network	Out-of-Network
Obesity Care Management (OCM) Program (Disease Management Program)		
Office Visit (OCM weight loss provider)	$0 Copay	Not Covered
Laboratory test	$0 Copay	Not Covered
Outpatient laboratory test services as determined by your weight loss provider (and as covered under this Plan). Outpatient laboratory tests must be performed at an in-network, free-standing, non-hospital-based lab facility such as Lab Corp or Quest. See Outpatient Laboratory Services for more information.		
Nutritional Counseling Services	$0 Copay	Not Covered
Nutritional Counseling Services are covered for enrolled OCM participants who are actively engaged in the program. Nutritional counseling services must be provided by a registered dietician or nutritionist. The frequency of the nutritional counseling services will be determined by the third-party claims administrator and will be based on medical necessity and engagement in the OCM program.		
OCM benefits subject to requirements/compliance with the OCM program as indicated in the Schedule of Medical Benefits Section.		

Benefit Description	In-Network	Out-of-Network
Vision Care Services		
Vision Exam	$10 Copay	$10 Copay
Limited to one exam per Plan Year, per covered individual. The maximum benefit this Plan will pay per Plan Year, per covered individual is $100.		
Prescription eyeglasses	$10 Copay	$10 Copay
Single vision, bifocal and trifocal lenses, and prescription contact lenses. *Eyeglasses, or contact lenses in lieu of eyeglasses, limited to $100 every 24 months.*		

Prescription Drug Benefits			
In-Network Pharmacy Benefits			
	Preferred Retail Network **Pharmacies*** (30-Day Supply)	**Smart90 Retail Pharmacies** (90-Day Supply)	**Home Delivery Express Scripts Pharmacy** (90-Day Supply)
Preferred Formulary Generic	$10 Copay	$20 Copay	$20 Copay
Preferred Formulary Brand	$40 Copay	$80 Copay	$80 Copay
Non-Preferred/Non-Formulary Brand	$75 Copay	$150 Copay	$150 Copay
Specialty Drugs			
Specialty Drugs Accredo Specialty Mail Order Pharmacy	N/A	N/A	You pay 30% after Deductible (30-Day Supply)
Benefit Description	**In-Network**		**Out-of-Network**
Hinge Health			
Digital Musculoskeletal (MSK) Care	$0 Copay		Not Covered

Preferred Retail Network** *Pharmacies: Copayments apply if you fill your prescription at a* **Preferred Retail Network** *retail pharmacy. If you fill your prescription at a non-Preferred Retail Network** *retail pharmacy, you will pay an additional $10 per prescription. If you currently use a non-***Preferred Retail Network** *pharmacy and you want to avoid the $10 upcharge, call an* **Preferred Retail Network** *pharmacy to transfer your prescription.*

Prescription drugs are not covered when purchased from Out-of-Network pharmacies.

See the Schedule of Medical Benefits in this document for important information related to pharmacy benefits, including how to find an **Preferred Retail Network** *and Smart90 pharmacy.*

Schedule of Medical Benefits

The *Schedule of Medical Benefits* provides a description of benefits, including certain limitations under this Plan. All covered services must be medically necessary and are subject to exclusions and limitations as described herein. Precertification is required for many services, plan benefit limitations apply to certain benefit categories, and out-of-network are not covered unless otherwise specified in this document.

When the Plan Administrator determines that two or more courses of treatment are substantially equivalent, the Plan Administrator reserves the right to substitute less costly services or benefits for those that this Plan would otherwise cover.

> *Example: If both inpatient care in a skilled nursing facility and intermittent, part-time nursing care in the home would be medically appropriate, and if inpatient nursing care would be less costly, this Plan could limit coverage to the inpatient care. This Plan could limit coverage to inpatient care even if this means extending the inpatient benefit beyond the quantity provided in the Summary of Medical Benefits or Schedule of Medical Benefits.*

The fact that a participating provider prescribed, ordered, recommended, or approved a service, treatment, or supply does not necessarily make it a covered service or medically necessary.

The *Summary of Medical Benefits and Schedule of Medical Benefits* should be read in conjunction with the *Benefit Limitations and Exclusions* and *Key Definitions Terms and Definitions*. The Explanations and Limitations may not include every limitation. For more information relating to a specific benefit, refer to *Utilization Management* (for any precertification requirements), *Exclusions*, *Key Terms and Definitions* and other sections that may apply to a specific benefit.

All claims must be submitted within twelve (12) months of the date of service to be considered for payment.

Acupuncture and Acupressure Services

Acupuncture and acupressure are covered under this Plan if performed by a licensed health care provider acting within the scope of that license. Acupuncture and acupressure services must be provided by In-Network and are limited to 20 visits per Plan Year, maximum 100 visits per lifetime.

Maintenance services are not a covered benefit.

Alcohol and Substance Abuse Services (inpatient and outpatient)

Medically necessary inpatient and outpatient alcohol and substance abuse services will be provided under the same terms as medical and surgical benefits, with no additional financial or treatment limitations. Substance abuse care benefits are for acute medical detoxification and for

substance abuse rehabilitation and counseling. The main purpose of medical detoxification is to rid the body of toxins, monitor heart rate, blood pressure and other vital signs, manage withdrawal symptoms and administer medications as needed.
Inpatient and outpatient programs for alcohol and substance abuse treatment require precertification. Alcohol and substance abuse office visits that are not part of an alcohol or substance abuse program do not require precertification.

Allergy Testing and Treatment

Coverage is provided for medically necessary allergy testing, preparation of serum, serum, and administration of injections. For allergy treatment only, the participant will be responsible for the lesser of the primary care or specialist office visit copay or the cost of the serum/injection.

Autism Spectrum Disorders

This Plan provides coverage for autism spectrum disorder per NRS 695G.1645 including coverage of screening for and diagnosis of autism spectrum disorders and for the treatment of autism spectrum disorders for covered dependents individuals.

Treatment of autism spectrum disorders must be identified in a treatment plan and may include medically necessary habilitative or rehabilitative care, prescription drug care, psychiatric care, psychological care, behavioral therapy, or therapeutic care that is:

- Prescribed for a person diagnosed with an autism spectrum disorder by a licensed physician or licensed psychologist; and
- Provided for a person diagnosed with an autism spectrum disorder by a licensed psychologist, licensed behavior analyst or other provider that is acting within the scope of their license.

Excludes coverage for reimbursement to an early intervention agency or school for services delivered through early intervention or school services.

Terms in the Autism Spectrum Disorders section of NRS have the definitions assigned to them in NRS 689B.0335 and not necessarily the definitions in this MPD.

Blood Services for Surgery

Medically necessary blood and related supplies provided during a surgical or other procedure that requires blood replacement are covered services.

Chemotherapy

Chemotherapy and other drug therapies that are medically necessary to treat cancers and other diseases and conditions are covered services. Covered when ordered by a physician; chemotherapy must be pre-certified by the UM company.

See prescription benefits for orally administered chemotherapy drugs:

Patients undergoing chemotherapy may be eligible for 1 wig, any type, synthetic or not, per Plan Year (excluding sales tax).

Clinical Trials

The routine medical treatment costs, including all items and services that are otherwise generally available to Plan participants, received as part of a clinical trial or study, may be covered under NRS 695G.173. A clinical trial is the process for testing of new types of medical care that are in the final stages of research to find better ways to prevent, diagnose or treat diseases.

Diabetic Services for Type 1, Type 2, and Gestational Diabetes

Coverage is provided for the medically necessary management and treatment of diabetes, including infusion pumps and related supplies, medication, equipment, supplies, and appliances for the treatment of diabetes.

Coverage is provided for the medically necessary self-management of diabetes for training and education provided after you are diagnosed with diabetes for the care and management of diabetes, including, counseling in nutrition and the proper use of equipment and supplies for the treatment of diabetes.

Durable Medical Equipment (DME)

Coverage is provided for the purchase, rental, repair, or maintenance of durable medical equipment prescribed by a provider for a medically necessary condition other than kidney dialysis. **DME is limited to one purchase, repair, or replacement of a specific item of DME every 3 years.** Rental of DME to cover Medicare guidelines concerning rental to purchase criteria. The purchase or rental of DME more than $1,000 requires precertification from the UM company.

Durable medical equipment is equipment that:

- Can withstand repeated use.
- Is not disposable.
- Is appropriate for use in the home.
- Is not useful in the absence of an illness or injury.
- Is prescribed by a physician.
- Meets CMS guidelines for coverage; and
- Is not primarily for convenience or comfort but serves a medical purpose.

Durable medical equipment includes, but is not limited to the following:

- Oxygen equipment (all oxygen and oxygen related equipment, except for oxygen while traveling on an airline).
- Wheelchairs.
- Hospital beds.
- Glucose monitors; and

- Warning or monitoring devices for infants (defined as a child 24-months old or less) suffering from recurrent apnea.

Coverage will be based on an amount equal to the generally accepted cost of durable medical equipment that provides the medically necessary level of care at the lowest cost.

Items not covered under this benefit include, but are not limited to: dressings, any equipment or supply to condition the air, appliances, ambulatory apparatus, arch supports, support stockings, corrective footwear, orthotics or other supportive devices for the feet, heating pads, personal hygiene, comfort, care, convenience or beautification items, deluxe equipment, and any other primarily non-medical equipment, except as otherwise covered and described within this *Schedule of Medical Benefits* and the *Benefit Limitations and Exclusions* sections.

Also excluded are exercising equipment, vibratory or negative gravity equipment, swimming or therapy pools, spas, and whirlpools (even if recommended by your medical provider to treat a medical condition).

Enteral Formulas and Special Food Products

Enteral Formulas and Special Food Products are covered in accordance with NRS 689B.0353.

Family Planning, Fertility, Infertility, Sexual Dysfunction Services and Male Contraception

Medical or surgical treatment for sexual dysfunction: There are some limits on sexual dysfunction drugs such as Viagra or Muse and are subject to the Plan Year Deductible. For more information, contact the pharmacy benefit manager

Coverage is provided for vasectomies and tubal ligations. Reversals of prior sterilization procedures, including, but not limited to tubal ligation and vasectomy reversals are excluded.

Medically necessary services for subscriber, spouse, and/or domestic partner to diagnose problems of infertility are covered for one workup per Plan Year up to three (3) evaluations per lifetime. For infertility services that are not covered under this Plan, see the *Benefit Limitations and Exclusions* section.

Bariatric/Weight Loss Surgery

Covered services include medically necessary surgical interventions to accomplish weight loss in individuals who are obese or morbidly obese *with* associated illnesses. These services may have a reduced benefit unless you receive precertification.

Bariatric weight loss surgery benefits, pre-and post-surgery, are available only when performed at an in-network Bariatric Surgery Center of Excellence facility, by an in-network surgeon and all ancillary providers. The third-party Claims Administrator will determine the in-network Bariatric Surgery Center of Excellence facility. It is the participant's responsibility to ensure that all

bariatric surgery services providers are in-network and facility chosen to provide services are in-network.

There is no payment if services are provided at an out-of-network facility or out-of-network surgeon, or other ancillary providers are used.

Participants are limited to one obesity related surgical procedure of any type in an individual's lifetime while covered under this Plan or any PEBP self-funded Plan. For example, a participant cannot have lap band surgery and subsequently seek benefits for gastric bypass. The first service related to surgical weight loss will be considered payable under this Plan, any others will not. If a participant had coverage under a different plan (any other plan other than a PEBP self-funded Plan) previously and subsequently had a bariatric surgery, they are still eligible to have one bariatric procedure paid for under the Plan, provided that all precertification criteria are met.

For lap band adjustments, the Plan will consider any adjustments made in the 12 months following surgery if the participant remains compliant with their post-surgical agreement as verified by the UM company. Any adjustments to the lap band after the first 12 months post-surgery will be subject to precertification.

It is the responsibility of the participant to ensure that their providers and facilities chosen to provide these services are in-network for benefits to be paid. Participants can verify the network status of any provider (including a facility) by calling the Claims Administrator located in the *Participant Contact Guide*.

Participants must receive treatment in a Bariatric Surgery Center of Excellence which has met the requirements outlined by the American College of Surgeons National Surgical Quality Improvement Program (ACS NSQIP) and is accredited by the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP). The accreditation of a Bariatric Surgery Center of Excellence helps identify providers with whom a participant should expect to receive safer and more effective surgical treatment. These MBSAQIP accredited providers adhere to a multidisciplinary surgical preparatory regimen to include but not limited to the following:

1. Behavior modification program supervised by a qualified professional.
2. Consultation with a dietician or nutritionist.
3. Documentation in the medical record of the participant's active participation and compliance with the multidisciplinary surgical preparatory regimen at each visit. A physician's summary letter, without evidence of concurrent oversight is not sufficient documentation. Documentation should include medical records of the physician's initial assessment of the participant, and the physician's assessment of the participant at the completion of the multidisciplinary surgical preparatory regimen.
4. Exercise regimen (unless contraindicated) to improve pulmonary reserve prior to surgery, supervised by an exercise therapist or other qualified professional.
5. Program must have a substantial face-to-face component (must not be entirely delivered remotely); and

6. Reduced-calorie diet program supervised by dietician or nutritionist.

If a participant has started any type of program to meet the pre-surgery criteria outlined below with an out-of-network provider (including a facility), those services will NOT be considered part of the Plan's mandatory precertification requirements. For the Plan to consider your bariatric surgery a covered benefit under this Plan; you will have to begin the precertification process again with the appropriate providers.

All services, pre- and post-surgery must be at an in-network facility, with in-network providers AND be at a certified Center of Excellence for bariatric weight loss.

Precertification/Pre-Surgery Criteria for Weight Loss Surgery
The participant or their physician must contact the UM company to begin the process toward surgical intervention for obesity. The initial contact will include:

- Notifying the participant that the precertification process begins with the initial contact to UM company.
- Notifying the participant that precertification requests presented to the UM company before the clinical criteria listed below has been completed will be denied. A precertification request may be reconsidered upon completion of the clinical criteria.
- Informing the participant of the requirement to access and participate in a weight management and nutrition program.
- Documenting participant completion of the associated assessments required to be considered for the procedure.
- Educating the participant on how to access wellness/preventive services and how to proceed with meeting the clinical indications listed below; and
- Advising participants of Centers of Excellence in bariatric surgery provider in their geographic area.

Clinical Criteria for Weight Loss Surgeries is managed by the UM Company.

Surgical or invasive treatments for obesity or morbid obesity including but not limited to bariatric weight/loss services, reversals, and treatments to resolve complications are generally excluded.
Travel Expenses:
This Plan provides reimbursement of certain costs associated with travel and hotel accommodations for the member and one additional person (spouse/domestic partner, family member or friend) when associated with bariatric/weight loss surgery and performed at a Center of Excellence that is located 50 or more miles from the member's residence. For travel expense benefits, refer to the Travel Expenses benefit section.

Expenses incurred for travel and hotel accommodations for bariatric/weight loss surgery not performed at a Center of Excellence are not covered.

Gender Dysphoria Related Services

This Plan provides benefits to individuals seeking medical services for the treatment of gender dysphoria.

All procedures, services, and supplies related to surgery and sex hormones associated with gender affirmation/confirmation should be reviewed by the UM Company for medical necessity.

The Plan limits a member ages 18 and older to one surgery type in an individual's lifetime while covered under any current or previous PEBP Plan.

Reversals of surgery to treat gender dysphoria will not be covered.

Genetic Counseling/Testing

Covered services include medically necessary genetic disease testing. Genetic disease testing is the analysis of human DNA, chromosomes, proteins, or other gene products to determine the presence of disease-related genotypes, phenotypes, karyotypes, or mutations for clinical purposes. Such purposes include those tests meeting criteria for the medically accepted standard of care for the prediction of disease risk, identification of carriers, monitoring, diagnosis, or prognosis within the confines of the statements in this definition. Coverage is not available for tests solely for research, or for the benefit of individuals not covered under the Plan.

Covered services also include the explanation by a genetic counselor of medical and scientific information about an inherited condition, birth defect, or other genome-related effects to an individual or family. Genetic counselors are trained to review family histories and medical records, discuss genetic conditions and how they are inherited, explain inheritance patterns, assess risk, and review testing options, where available.

Genetic testing may only be done after consultation with an appropriately certified genetic counselor and/or, in our discretion, as approved by a physician that we may designate to review the utilization, medical necessity, clinical appropriateness, and quality of such genetic testing. Medically necessary genetic counseling will be covered in connection with pregnancy management with respect to the following individuals:

- Expenses for genetic tests, except where otherwise noted in this document, including obtaining a specimen and laboratory analysis, to detect or evaluate chromosomal abnormalities, or genetically transmitted characteristics including:
- Pre-parental genetic testing intended to determine if a prospective parent or parents have chromosomal abnormalities that are likely to be transmitted to a child of that parent or parents; and
- Prenatal genetic testing intended to determine if a fetus has chromosomal abnormalities that indicate the presence of a genetic disease or disorder, except that payment is made for fluid or tissue samples obtained through amniocentesis, non-

invasive pre-natal testing for fetal aneuploidy, chorionic villus sampling (CVS), fetoscopy and alpha fetoprotein (AFP) analysis in pregnant women.

- Participants should contact the Plan's Claims Administrator to determine if proposed genetic testing is covered or excluded and the UM company for precertification requirements. See also the exclusions related to prophylactic surgery or treatment later in this section.

Genetic Counseling except as related to covered genetic testing as listed in the Genetic Testing and Counseling and the Preventive Covered services include genetic testing of heritable disorders as medically necessary when the following conditions are met:

- The results will directly impact clinical decision-making and/or clinical outcome for the individual.
- The testing method is considered scientifically valid for identification of a genetically linked heritable disease; and
- One of the following conditions is met:
    - The participant demonstrates signs/symptoms of a genetically linked heritable disease, or
    - The participant or fetus has a direct risk factor (e.g., based on family history or pedigree analysis) for the development of a genetically linked heritable disease.

Additional genetic testing/counseling will be covered in accordance with federal or state mandates.

In the absence of specific information regarding advances in the knowledge of mutation characteristics for a disorder, the current literature indicates that genetic tests for inherited disease need only be conducted once per lifetime of the member.

Routine panel screening for preconception genetic diseases, routine chorionic villous sampling, or amniocentesis panel screening testing, and pre-implantation embryonic testing will not be covered unless the testing is endorsed by the American College of Obstetrics and Gynecology or mandated by federal or state law.

Hearing Aids

Air conduction hearing aids are considered medically necessary when one or more of the following hearing loss criteria are met *in either or both ears*:

1. Hearing thresholds 40 dB HL or greater at <u>two or more</u> of these frequencies: 500, 1000, 2000, 3000, 4000 Hz; or
2. Hearing thresholds 26 dB HL or greater at <u>three</u> of these frequencies; or
3. For high frequency hearing loss, defined as loss occurring only above 2000 Hz:
    a. Hearing thresholds of 26 dB HL or greater at <u>three or more</u> of these frequencies: 2000, 3000, 4000, 6000 or 8000 Hz

4. Speech recognition less than 80 percent in either or both ears regardless of hearing threshold level.

Participants who meet the above hearing loss criteria: Each air conduction hearing aid is subject to a $50 copay (per device, per each ear), with maximum plan benefit of $1,500 per device every three (3) years.

Participants may submit a copy of their hearing aid payment receipt from the hearing aid provider to the third-party claims administrator to request reimbursement for the hearing aid benefit, less applicable copayment(s), and deductibles to receive credit towards the Out-of-Pocket Maximum.

Over the Counter hearing aids are excluded from the Plan.

Home Health Care

Medically necessary home health care is covered if such care is provided by an organization or professional licensed by the state to render home health services. Such care will not be available if it is substantially or primarily for the participant's convenience or the convenience of a caregiver. Home care is covered in the home only on a part-time and temporary basis and to the extent that such care is performed by a licensed or registered nurse or other appropriate therapist or provider acting within the scope of their license.

Home health care covered includes skilled nursing care, therapies, and other health related services provided in the home environment for other than convenience for patient or patient's family, personal assistance, or maintenance of activities of daily living or housekeeping. Covered home health care services under this part include home health care provided by a professional as the nature of the illness dictates.

Excluded from coverage as home health care are:

- Personal care, custodial care, domiciliary care, or homemaker services.
- In-home services provided by a licensed provider acting within the scope of their license.
- Over-the-counter medical equipment, over-the-counter supplies, or any prescription drugs, except to the extent that they are covered elsewhere in this *Schedule of Medical Benefits*.

Mastectomy and Reconstructive Surgery

Breast reconstructive surgery and the internal or external prosthetic devices are covered for members who have undergone mastectomies or other treatments for breast cancer. Treatment will be provided in a manner determined in consultation with the physician and the member. Subject to all the terms and conditions of this *Schedule of Medical Benefits*, if a covered mastectomy or other breast cancer treatment is performed, we will also provide coverage for:

All stages of reconstruction of the breast on which the mastectomy has been performed.

- Surgery and reconstruction of the other breast to produce a symmetrical structure.
- Prostheses; and
- Physical complications for all stages of mastectomy, including lymphedemas.

If reconstructive surgery occurs within three years after a mastectomy, the amount of the benefits for that surgery will equal the amounts provided for in the Plan at the time of the mastectomy. If the surgery occurs more than three years after the mastectomy, the benefits provided are subject to all the terms, conditions, and exclusions contained in the Plan at the time of reconstructive surgery.

This Plan complies with the Women's Health and Cancer Rights Act of 1998 (WHCRA) Breast reconstructive surgery and the internal or external prosthetic devices are covered for members who have undergone mastectomies or other treatments for breast cancer. Treatment will be provided in a manner determined in consultation with the physician and the member. For any covered individual who is receiving mastectomy-related benefits, coverage will be provided for:

- All stages of reconstruction of the breast on which the mastectomy has been performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- External prostheses (breast forms that fit into your bra) that are need before or during reconstruction; and Treatment of physical complications of all stages of the mastectomy, including lymphedema (fluid build-up in the arm and chest on the side of the surgery).

Treatment of leaking breast implant is covered when the breast implant surgery was performed for reconstructive services following a partial or complete mastectomy as mandated by the Women's Health and Cancer Rights Act.

Participants should use the Plan's precertification procedure to determine if a proposed surgery or service will be considered cosmetic surgery or medically necessary reconstructive services.

Medical Care

Medically necessary medical care and services, performed by a physician or other professional on an inpatient and outpatient basis, are covered, including:

- Office visits and consultations.
- Hospital and skilled nursing facility services.
- Ambulatory surgical center services.
- Home health care services.

- Surgery; and
- Other professional services.

Note: The Plan Administrator or its designee will determine if multiple surgical or other medical procedures will be covered as separate procedures or as a single procedure based on the factors in the Surgery/Surgeries definition in the *Key Terms and Definitions* section.

Assistant surgeon fees will be reimbursed for medically necessary services to a maximum of 20% of the eligible expenses payable to the primary surgeon. See Certified Surgical Assistant in the *Key Terms and Definitions* section.

Mental Health Services

Medically necessary mental health services provided by a doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other qualified mental health care professional are covered according to the limits provided in the *Schedule of Medical Benefits* sections.

All outpatient partial hospitalization programs, partial residential treatment programs, and inpatient services for mental health require precertification. This Plan provides mental health benefits in accordance with the MHPAEA.

Maternity and Newborn Services

Medically necessary maternity services for pregnant participants are covered, including prenatal and postpartum care, related delivery room and ancillary services and newborn care. Newborn care includes care and treatment of medically diagnosed congenital defects, birth abnormalities, or prematurity, and transportation costs of newborn to and from the nearest facility staffed and equipped to treat the newborn's condition. Newborn care is subject to the eligibility requirements as defined in the *Schedule of Medical Benefits*.

Notwithstanding anything in this *Schedule of Medical Benefits* to the contrary, participant does not need precertification from the UM company to obtain access to obstetrical or gynecological care from a professional in this Plan's network who specializes in obstetrics or gynecology. The provider, however, may be required to comply with certain procedures, including obtaining precertification for certain services, following a preapproved treatment plan, or procedures for making referrals. For a list of participating providers who specialize in obstetrics or gynecology, refer to the Low Deductible PPO Plan network at *www.pebp.state.nv.us*.

Notwithstanding anything in this *Schedule of Medical Benefits* to the contrary, in the case of a person who has a child enrolled in coverage, this Plan will permit such person to designate any pediatrician as a primary care physician if such pediatrician is a participating provider.

When the member has Employee-Only coverage, the newborn will be covered under the member's plan for the first 31 days (NRS 689B.033). Individual deductible, copay, coinsurance, and out of pocket limitations, where applicable, will apply during the initial coverage period.

Services that are not covered include:

- Amniocentesis to the extent that it is performed to determine the sex of the child.
- Non-newborn circumcisions after eight weeks of age unless medically necessary and provided a precertification.

Obesity Care Management Program

The Obesity Care Management (OCM) Program is open to participants who have been diagnosed as obese by their physician and who meet the criteria set out in this section.

Participants who opt-in to the OCM Program may be eligible for enhanced benefits. These benefits include:

- Services provided by an in-network provider certified by the American Board of Bariatric Medicine (ABBM) and specializes in weight loss services or if there is no certified provider within 50 miles of a participant's residence, services may be provided by any in-network provider.
- Laboratory tests provided by an in-network free-standing, non-hospital-based outpatient laboratory facility such as Lab Corp or Quest.
- Nutritional counseling services when provided in-network, frequency is determined by the Claims Administrator and is based on medical necessity.

Weight Loss Medications:

- The Plan covers certain only short-term use obesity/weight loss generic medications as identified by the Plan's Pharmacy Benefits Manager. Contact the Pharmacy Benefit Manager or refer to the Plan's prescription drug formulary to determine what weight loss medications are covered by the enhanced benefit. Long-term weight loss medications are excluded.
- This Plan does not coordinate prescription drug plan benefits.

Medications purchased at non-participating pharmacies are not covered under this Plan.

Gym memberships, exercise equipment and bariatric restrictive weight loss surgery is not included in the OCM benefits. Refer to the *Summary of Medical Benefits* section for more information.

For enrollment information, please contact the Claims Administrator as listed in this document under the *Participant Contact Guide*. When you enroll in the program, your effective date will typically be the 1st of the month following your enrollment in the program. The effective date will be determined by PEBP.

The information described in this section provides a summary of the Program's functions. For more detailed information, please contact the Claims Administrator.

The Obesity Care Management Program is optional and considered an "opt-in" Program. To be eligible for the enhanced wellness benefits, participants must meet certain criteria and adhere to certain participation requirements.

Once you have met your final weight loss goal as determined by your weight loss provider at the onset of your participation in a medically supervised weight loss program, benefits under the Obesity Care Management Program will end. This Plan does not provide benefits for ongoing maintenance care. If you choose to receive ongoing maintenance care, you will be responsible for the cost of receiving the services.

The Claims Administrator provides an Obesity Care Management Participant Program navigation guide available through the PEBP Member Portal, see the *Participant Contact Guide* for more information.

The Obesity Care Management Program is administrated by the Claims Administrator.

Engagement in the Program
You must remain actively engaged in a medically supervised weight loss program.

Monitoring Engagement
The Claims Administrator will assist your weight loss provider with completing monthly progress reports. The initial report should include your weight and BMI or waist circumferences, and a description of your treatment plan to include weekly weight loss goals, final weight loss goal, exercise regimen, diet, and nutrition instructions. Subsequent monthly reports should provide information regarding your weight loss progress and adherence to the treatment plan. Submission of these reports will be a requirement for payment under the enhanced wellness benefits. If your monthly weight loss reports are not received by the Claims Administrator, your benefits under this program will end, and your coverage will return to the standard LD PPO Plan benefits where other Plan limitations will apply. The effective date of the return to the standard Low Deductible PPO Plan benefits will be the first day of the month following the non-compliance notification received from the Claims Administrator.

How to Enroll in the Obesity Care Management Program

1. Contact the Claims Administrator for a list of in-network weight loss providers. This information is located on the Claims Administrator's website by logging into the E-PEBP Portal.
2. Make an appointment with an in-network weight loss provider. The Claims Administrator can also help you identify which in-network provider may best meet your needs, based on geography or other specialized needs you may have.

3. When you make an appointment with your in-network weight loss provider, before you go, be sure to take an Obesity Care Management Program Enrollment form with you. This form is located on the Claims Administrator's website under forms.
4. Have your in-network weight loss provider complete the enrollment form and submit (by mail or fax) the completed form to the Claims Administrator. Their name, address and fax number are provided on the enrollment form.
5. The Claims Administrator will review the information submitted by your provider and if the information indicates that you meet the criteria for the weight loss program benefits, the Claims Administrator will enroll you in the program. The Claims Administrator will notify PEBP and the Pharmacy Benefit Manager of your enrollment. If you do not meet the criteria for weight loss benefits, the Claims Administrator will notify you of the denial of benefits.
6. Engagement in the Program.

Benefits under the Obesity Care Management Program

The following benefits are included, many at no cost to you, when provided under this program subject to the limits in the *Summary of Medical Benefits* section:

- Office Visits.
- Laboratory tests.
- Nutritional counseling.
- Meal replacement therapy; and
- Certain medications under the prescription drug component of the Plan.

Oral Surgery, Dental Services, and Temporomandibular Joint Disorder

Medically necessary oral surgery procedures are covered (inpatient or outpatient) related to the following:

- Accidental injury to the jaw bones or surrounding tissues when the injury occurs, and the repair must commence within 90 days after the accidental Injury, regardless of date enrolled in the plan. Services that commence after 90 days are not covered unless determined to be medically appropriate.
- Treatment for tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, and roof and floor of the mouth.
- Non-dental surgical procedures and hospitalization required for newly born and children placed for adoption or newly adopted to treat congenital defects, such as cleft lip and cleft palate.
- Repair and restoration of teeth from injuries that arise from non-gustatory trauma.
- Extraction of teeth when related to radiation therapy or in advance of an organ transplant (other than a corneal transplant).
- Medical or surgical procedures occurring within or adjacent to the oral cavity or sinuses including treatment of fractures.

- Under certain circumstances (listed below) the medical Plan will pay for the facility fees and anesthesia associated with medically necessary dental services if the utilization review company determines that hospitalization is medically necessary to safeguard the health of the patient during performance of dental services:
    - Dental general anesthesia for a beneficiary when services are rendered in a hospital or outpatient surgical facility, when enrolled individual is being referred because, in the opinion of the dentist, the individual:
        - Is under age 18 and has a physical, mental, or medically compromising condition; or
        - Is under age 18 and has dental needs for which local anesthesia is ineffective because of an acute infection, an anatomic anomaly, or an allergy; or
        - Patient has a documented mental or physical impairment requiring general anesthesia for the safety of the patient.
        - Is under age seven (7) and diagnosed with extensive dental decay substantiated by x-rays and narrative reporting provided by the dentist.
        - No payment is extended toward the dentist or the assistant dental provider under this Plan. Refer to the dental benefits described in the PEBP Self-funded PPO Dental Plan Master Plan Document available at *www.pebp.state.nv.us*.

Temporomandibular Joint Disorder (TMJ) and dysfunction services and supplies including night guards are covered only when the required services are not recognized dental procedures. TMJ surgeries are covered under the medical benefits based on medical necessity and are limited to an annual maximum of one surgery and a lifetime maximum of two (2) surgeries.

Precertification is required for dental general anesthesia in a hospital or outpatient surgical facility. Dental anesthesiology services are covered only for procedures performed by a qualified specialist in pediatric dentistry, a dentist educationally qualified in a recognized dental specialty for which hospital privileges are granted or who is certified by completion of an accredited program of post-graduate hospital training to be granted hospital privileges.

Only the services and supplies described above are covered, even if the condition is due to a genetic, congenital, or acquired characteristic. Exclusions include:

- Except as described above as an inclusion, services involving treatment to the teeth; extraction of teeth; repair of injured teeth; general dental services; treatment of dental abscesses or granulomas; treatment of gingival tissues (other than for tumors); dental examinations; restoration of the mouth, teeth, or jaws because of injuries from biting, chewing, or accidents; artificial implanted devices; braces; periodontal care or surgery; teeth prosthetics and bone grafts regardless of etiology of the disease process; and repairs and restorations except for appliances that are

medically necessary to stabilize or repair sound and natural teeth after an injury as set forth above;
- Dental and or medical care including mandibular or maxillary surgery, orthodontia treatment, oral surgery, pre-prosthetic surgery, any procedure involving osteotomy to the jaw, and any other dental product or service except as set forth above.
- Treatment to the gums and treatment of pain or infection known or thought to be due to dental or medical cause and near the teeth or jaw, braces, bridges, dental plates or other dental orthosis or prosthesis, including the replacement of metal dental fillings; and
- Other supplies and services including but not limited to cosmetic restorations, veneers, implants, cosmetic replacements of serviceable restorations, and materials (such as precious metals).

Orthopedic Devices and Prosthetic Devices

Coverage for orthopedic devices is limited to medically necessary braces for problems requiring complete immobilization or for support, or if the braces are custom fitted or have rigid bar or flat steel supports and stays, splints, devices for congenital disorders, post, and pre-operative devices.
One medically necessary prosthetic device, approved by the Centers for Medicare & Medicaid Services (CMS), is covered for each missing or non-functioning body part or organ every three years. Coverage is limited to:

- Devices that are required to substitute for the missing or non-functioning body part or organ.
-
- Adjustment of initial prosthetic device; and
- The first pair of eyeglasses or contact lenses (up to the Medicare allowable) immediately following cataract surgery.
- Repair and replacement of prosthetic devices is not covered except in limited situations involving mastectomy reconstructive surgery.

Orthopedic shoes, foot orthotics or other supportive devices of the feet are excluded, except when such devices are:
- An integral part of a covered leg brace and its expense is included as part of the cost of the brace:
- For diabetes mellitus and for foot deformity, history of pre-ulcerative calluses, history of previous ulceration, peripheral neuropathy with evidence of callus formation, poor circulation or previous amputation of the foot or part of the foot:
- For rehabilitation prescribed as part of post-surgical or post-traumatic casting care; or
- Prosthetic shoes for members with a partial foot.

Ostomy Care Supplies

Coverage is provided for medically necessary care and supplies after colon, ileum, or bladder surgery to assist in carrying on normal activities with a minimum of inconvenience.

Partial Hospitalization Services

Partial hospitalization services are covered for mental illness and substance abuse according to the benefits listed in the *Schedule of Medical Benefits*. The same services covered for inpatient services are also covered for partial hospitalization. One inpatient day is defined as an admission to a facility for more than 12 hours of treatment. One partial treatment day is defined as no less than three and no more than 12 hours of therapy per day. Partial day treatment is covered only when the member receives care through a day treatment program.

Podiatry Services

Podiatry services are covered for the medically necessary treatment of acute conditions of the foot such as infections, inflammation, or injury and other foot care that is disease related.

The following services are not covered:

- Non-symptomatic foot care such as the removal of warts (except plantar warts); corns or calluses; and including but not limited to podiatry treatment of bunions, toenails, flat feet, fallen arches, and chronic foot strain; and routine foot care.

Preventive Services

Notwithstanding anything to the contrary in this *Summary of Medical Benefits*, the following preventive services will be covered without any participant cost-sharing if such services are provided by a participating provider:

- Periodic physical examinations and routine immunizations.
- Routine gynecologic examination (one per Plan Year), including annual cytologic screening test (Pap smear) for women 18 years of age or older, pelvic examination, urinalysis, and breast examination.
- Screening mammograms every 1-2 years for women 40 years of age or older.
- Well-baby care, including immunizations in accordance with the American Academy of Pediatrics.
- Colorectal cancer screening starting at age 45 years in accordance with:
    - The guidelines published by the American Cancer Society; or
    - Other guidelines or reports concerning such screening that are published by nationally recognized professional organizations and that include current or prevailing supporting scientific data.
- Immunizations, including COVID-19, influenza, pneumococcal, Haemophilus influenza B, hepatitis A, hepatitis B, hepatitis C, rubella, measles, diphtheria, human

papillomavirus (HPV), pertussis (whooping cough), poliovirus, rotavirus, varicella (chickenpox), shingles (herpes zoster) and tetanus, if such immunizations have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved (Note: Immunizations related to foreign travel or employment are excluded.);

- Hearing and vision screening for children through age 17 to determine the need for hearing and vision correction.
- Evidence-based items or services that have an "A" or "B" Recommendation by the United States Preventive Services Task Force (USPSTF) and Section 2713(a)(5) of the Public Health Service Act and Section 9(h)(v) (229) of the 2015 Consolidated Appropriations Act.
- With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration of the U.S. Department of Health and Human Services guidelines including the American Academy of Pediatrics Bright Futures guidelines; and
- With respect to women, such additional preventive care and screenings not described under this section as provided for in comprehensive guidelines supported by the Health Resources and Services Administration of the U.S. Department of Health and Human Services.

Human Papillomavirus testing and vaccination under NRS 695G.171.

Women's Contraceptives

This Plan covers all FDA approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity. The FDA requires the services to be "prescribed" by a physician even for over-the-counter methods. This Plan also adheres to NRS 695G.1715.

Colorectal Cancer Screening

Colorectal screening tests are covered at 100% when provided in-network for adults aged 45 years and older who are at average risk of colorectal cancer in accordance with the American Cancer Society's qualified recommendations; or beginning at age 40 for members with a high-risk of colorectal cancer. For more information regarding colorectal screening guidelines, contact the Claim's Administrator.

Screening Mammograms (2-D or 3-D)

Preventative 2-D or 3-D mammograms are covered at 100% for women age 40 years and older under the Affordable Care Act and USPSTF, or beginning at age 35 for members with a high-risk of breast cancer, when performed in-network.

Healthy Diet and Physical Activity for Cardiovascular Disease Prevention in Adults With Cardiovascular Risk Factors: Behavioral Counseling Interventions

Healthy Diet/Physical Activity Counseling and Obesity Screening/Counseling for adults aged 18 years and older are covered under the Wellness/Preventive Care Benefit when the Participant or covered dependent is referred by a primary care practitioner; for those who are obese; and have additional cardiovascular disease (CVD) risk factors. This wellness/preventive benefit is limited to twelve (12) Health Diet/Physical Activity Counseling or Obesity Screening/Counseling sessions according to recommendations from the USPSTF.

Smoking/Tobacco Cessation

- Prescription and over-the-counter smoking/tobacco cessation products are covered under the prescription drug program. Over-the-counter smoking cessation products must be accompanied by a prescription written by a physician.
  - Some examples of cessation products eligible to be paid at 100% include Chantix (by prescription only), nicotine gum, nicotine patches, and nicotine lozenges. Some limitations on quantity may apply and are at the discretion of the Pharmacy Benefit Manager and your physician.
- Benefits for over-the-counter products are limited to those that are FDA approved and recommendations by the Surgeon General.
- Over-the-counter smoking/tobacco cessation products may be obtained by presenting your physician's written prescription to an In-Network pharmacy, or you can submit your purchase receipt for the product with your physician's written prescription attached to the Prescription Drug Reimbursement Claim Form (this form is located at www.pebp.state.nv.us).
- Second-line therapies such as clonidine hydrochloride and nortriptyline hydrochloride are sometimes used in the management of smoking/tobacco-cessation; however, due to the lack of an FDA-approved indication for smoking cessation, as well as undesirable side effect profiles, currently prohibit these agents from achieving first-line classification and therefore, not covered under the *Preventive Care/Wellness Services* Benefit.
- The Plan does not cover electronic cigarettes.

For more information, please visit:

***Preventive Services for Adults and Families**: Visit the U.S. Preventive Task Force at https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-and-b-recommendations*

***Preventive Services for Women, Including Pregnant Women:** Visit Human Resources & Services Administration (HRSA) at https://www.hrsa.gov/womens-guidelines/index.html*

***Vaccines for infants, children, and teens:** Visit the U.S. Department of Health & Human Services at https://www.hhs.gov/vaccines/index.html*

Vaccines & Immunizations: *Visit the Centers for Disease Control and Prevention at https://www.cdc.gov/vaccines/index.html*

Preventive Health Services: *Visit HealthCare.gov at https://www.healthcare.gov/coverage/preventive-care-benefits/*

Preventive care services identified through the above links are recommended services. It is up to the participant and their physician or provider of care to determine which services to provide. The Plan Administrator has the authority to determine which services and quantity limits will be covered at the 100% wellness benefit; unless otherwise mandated by the Affordable Care Act or mandated in accordance with applicable Nevada Revised Statutes.

Note: This Plan complies with NRS 695G as related to contraceptive methods, utilization management, step therapy, prior authorization, categorization of prescription drugs (meaning Preferred Generic, Preferred Brand and Non-Preferred Brands), and cost-sharing.

Radiation Therapy

The Plan covers medically necessary specialty radiology when ordered by a physician or health care practitioner acting with the scope of their license, including, but not limited to, MRI, MRA, MRS MRT, PET, SPEC, and CT scan. See the *Utilization Management* (Prior Authorization) section for precertification requirements.

The Plan covers technical and professional fees associated with:

- diagnostic and curative services, including radiation therapy, and
- pre-admission testing: Outpatient radiology tests performed 7 days prior to a scheduled hospital admission or outpatient surgery. The testing must be related to the sickness or injury for which admission or surgery is planned.

Real Appeal

Nevada Public Employees' Benefits Program has partnered with UMR's Real Appeal program. Real Appeal provides eligible members a benefit for virtual weight loss and weight management coaching sessions. Sessions are covered under the preventive care benefit resulting in no cost-share to members. Real Appeal supports members eighteen (18) years of age and older.

This support includes, but not limited to, one-on-one coaching and online group sessions with supporting video content delivered by a virtual coach.

A qualified enrolled member will receive:

- Access to a coaches who will guide you through the program and develop a custom plan that fits your needs, preferences, and goals.
- 24/7 access to digital tools and dashboards.
- A Real Appeal kit containing health weight management tools that may include fitness guides, recipes, digital food and weight scales

- Support from online group classes with a coach and other members who share what's helped them achieve success.

For more information, contact the Plan's third-party claims administrator listed in the Participant Contact Guide.

Rehabilitative and Habilitative Therapy

Coverage is provided for medically necessary physical, speech, occupational, cardiac, and pulmonary therapy habilitative and rehabilitation services that are performed by a physician or by a therapy provider licensed in accordance with state regulations for that therapy discipline.

Coverage for these services is available for acute conditions arising from illness or injury, as well as chronic or developmental conditions up to the benefit limits as defined in the benefit Plan.

- Prior authorization for outpatient rehabilitative and habilitative therapy (occupational, physical, or speech) exceeding 90 combined visits per Plan Year (limit not applied to therapy treating a behavioral health condition).
- There is no limit for Cardiac Rehabilitation services.

Skin Lesions

Coverage is provided for medically necessary removal of skin lesions and related pathological analysis of such lesions. Coverage is provided for the removal of port wine lesions.

Chiropractic Services Spinal Manipulation (non-surgical)

Coverage is provided for up to 20 visits per Plan Year for medically necessary spinal manipulations and adjustments.

Maintenance services are not a covered benefit.

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Transplant Services (Organ and Tissue)

Medically necessary organ transplants at an approved Center of Excellence are covered when you are the organ recipient in the following cases:

- Bone marrow.
- Cornea.
- Heart.
- Heart and lung.
- Intestinal and liver.
- Kidney.
- Liver.

- Lung.
- Pancreas.
- Pancreas and kidney; and
- Stem cell.

Centers of Excellence are facilities that meet vigorous credentialing requirements for the specific type of organ transplant. A facility that is designated as a Center of Excellence for one type of organ transplant may not be designated as a Center of Excellence for another type of organ transplant. Designation as a Center of Excellence is at the UM company's sole discretion.

Organ transplants are only covered where the organ donor's suitability meets the OPTN/UNOS (Organ Procurement and Transplantation Network/United Network for Organ Sharing) donor evaluation and guideline criteria, when applicable.

Coverage for related transplant services is limited to:

- Tests necessary to identify an organ donor.
- The reasonable expense of acquiring the donor organ.
- Transportation of the donor organ (but not the donor), and life support where such support is for the sole purpose of removing the donor organ.
- Storage costs of an organ, but only as part of an authorized treatment protocol; and
- Follow-up care.

The following services are excluded from coverage:

- Services provided at a facility that has not been designated as an approved Center of Excellence.
- Services provided to an organ donor unless otherwise specified elsewhere in this document.
- Services provided in connection with purchasing or selling organs.
- Transplants utilizing any animal organs.
- Any transportation of the donor (as opposed to transportation of the donor organ only) is excluded, except as otherwise covered under the *Travel Expense* section for transplant services.
- Any expenses associated with an organ transplant where an alternative remedy is available are excluded.
- Artificial heart implantation is excluded.
- Services for which government funding or other insurance coverage is available are excluded.
- Tissue transplants (whether natural or artificial replacement materials or devices are used) or oral implants, including the treatment for complications arising from tissue or organ transplants or replacement are excluded, except as described above.

Hospital, Skilled Nursing Care, and Services in an Outpatient Surgical Center

Inpatient Care

Medically necessary inpatient hospital care is covered. Services include, but are not limited to:

- Services for medical conditions treated in an acute care hospital inpatient environment.
- Semi-private room and board (private room when medically necessary).
- General nursing care facilities, services, and supplies on an inpatient basis.
- Diagnostic services that are provided in a facility, whether such facility is a hospital or a freestanding facility. For related covered services refer to Other Services and Supplies in the *Schedule of Medical Benefits* section.
- Surgical and obstetrical procedures, including the services of a surgeon or specialist, assistant, and anesthetist or anesthesiologist together with preoperative and postoperative care.
- Maternity and newborn care for up to 48 hours of inpatient care for a mother and her newborn child following a vaginal delivery and up to 96 hours of inpatient care for a mother and her newborn child following a cesarean delivery. The time-periods will commence at the time of the delivery. Any decision to shorten the length of inpatient stay to less than those time-periods will be made by the attending physician after conferring with the mother.
- Inpatient, short-term rehabilitative services, limited to treatment of conditions that are subject to significant clinical improvement over a continuous 30-day period from the date inpatient therapy commences in a distinct rehabilitation unit of a hospital, skilled nursing facility, or other facility approved by us (limited to 100 days per Plan Year).
- Inpatient alcohol and substance abuse rehabilitation services in a hospital, residential treatment facility, or day treatment program; and
- Inpatient mental health services.

Inpatient services to treat mental illness conditions are subject to medical necessity. Provider visits received during a covered admission are also covered. Benefits are provided for medically necessary inpatient care, outpatient care, partial hospitalization, and provider office services for the diagnosis, crisis intervention and treatment of severe mental illness conditions and substance abuse conditions as noted in the *Schedule of Medical Benefits*.

Inpatient services must be provided by a licensed hospital, psychiatric hospital, alcoholism treatment center, or residential treatment center.

The member should contact the UM company to determine medical necessity, appropriate treatment levels and appropriate settings. Inpatient services are subject to precertification notification guidelines to avoid potential penalties related to non-notification of services.

If you are incapacitated and you (or a friend or relative) cannot notify the UM company within the above stated times in the UM section, above, the UM Company must receive notification as soon as reasonably possible after the admission or you may be subject to reduced benefits as provided in this Plan.

Medically necessary care at a skilled nursing facility (limited to 100 days per Plan Year) for non-custodial care is covered. A skilled nursing facility is a facility that is duly licensed by the state and/or federal government and that provides inpatient skilled nursing care, rehabilitation services, or other related health services that are not custodial or convenience in nature. Skilled nursing care includes medically necessary services that are considered by Medicare to be eligible for Medicare coverage as meeting a skilled need and that can only be performed by, or under the supervision of, a licensed or registered nurse. This Plan does not cover skilled nursing care that is not covered by CMS. Prior care in a hospital is not required before being eligible for coverage for care in a skilled nursing facility.

Outpatient Care

Medically necessary outpatient hospital or outpatient surgical center care is covered. Services furnished in a hospital or outpatient surgical center premises are covered, including use of a bed and periodic monitoring by a hospital's nursing or other staff that are medically necessary to evaluate an outpatient's condition or determine the need for a possible admission to the hospital. If a hospital intends to keep a patient in observation status for more than 48 hours, observation status will become an inpatient admission for administration of benefits.

Coverage for the following benefits is dependent upon the benefits described in the ***Schedule of Medical Benefits*** for this Plan. Mental health and substance abuse outpatient services include, but are not limited to:

- Services for medical conditions treated in an acute care hospital outpatient environment.
- Semi-private room and board (private room when medically necessary) if patient is in observation status.
- General nursing care facilities, services, and supplies on an outpatient basis.
- Diagnostic services that are provided in a facility, whether such facility is a hospital or a freestanding facility.
- Surgical and obstetrical procedures, including the services of a surgeon or specialist, assistant, and anesthetist or anesthesiologist together with preoperative and postoperative care.
- Outpatient, short-term rehabilitative services.
- Outpatient alcohol and substance abuse rehabilitation services in a hospital, hospital residential treatment facility, or day treatment program; and
- Outpatient mental health services.

Medically necessary short-term outpatient habilitative and rehabilitative services are covered for:

- Short-term speech, physical, and occupational habilitative and rehabilitative therapy for acute conditions that are subject to significant clinical improvement over a 90-day period, as determined by the UM company, from the date outpatient therapy commences or to maintain function in an individual. Precertification required for habilitative and rehabilitative therapy exceeding a combined visit limit of 90 visits per Plan Year: and
- Services for cardiac rehabilitation and pulmonary rehabilitation (limited to 60 visits/sessions per Plan Year for each type of therapy).

Medically necessary services such as radiation therapy and chemotherapy (including chemotherapy drugs), are covered to the extent that such services are delivered in the most appropriate clinical manner and setting as part of a treatment plan.

Services that are not covered under this benefit include:

- Any services or supplies furnished in an institution that is primarily a place of rest, a place for the aged, a custodial facility, or any similar institution.
- Private duty nursing and private rooms in an inpatient setting.
- Personal, beautification, or comfort items for use while in a hospital or skilled nursing facility; and
- Services related to psychosocial rehabilitation or care received as a custodial inpatient.

No Surprises Act

The federal No Surprises Act protects patients who receive emergency services at a hospital, at an independent freestanding emergency department and from air ambulances. In addition, the law protects patients who receive emergency services from a Non-PPO provider at an in-network facility. Beneficiaries receiving these services will only be responsible for paying their in-network cost sharing and cannot be balance billed by the provider or facility for emergency services.

Emergency Services

Emergency Services are covered:

- Without the need for a prior authorization determination, even if the services are provided out-of-network;
- Without regard to whether the health care provider furnishing the Emergency Services is a PPO provider or a PPO emergency facility, as applicable, with respect to the services;
- Without imposing any administrative requirement or limitation on out-of-network Emergency Services that is more restrictive than the requirements or limitations that apply to Emergency Services received from PPO providers and PPO emergency facilities;
- Without imposing cost-sharing requirements on out-of-network Emergency Services that are greater than the requirements that would apply if the services were provided by a PPO provider or a PPO emergency facility;

- By calculating the cost-sharing requirement for out-of-network Emergency Services as if the total amount that would have been charged for the services were equal to the Recognized Amount for the services; and
- By counting any cost-sharing payments made by the participant or beneficiary with respect to the Emergency Services toward any in-network deductible or in-network out-of-pocket maximums applied under the plan (and the in-network deductible and in-network out-of-pocket maximums are applied) in the same manner as if the cost-sharing payments were made with respect to Emergency Services furnished by a PPO provider or a PPO emergency facility.

Your cost sharing amount for Emergency Services from Non-PPO Providers will be based on the lessor of billed charges from the provider or the Qualified Payment Amount (QPA).

*see also NRS 695G.170 for medically necessary emergency services at any hospital in Nevada.

Post Stabilization Services

Emergency Services furnished by a Non-PPO Provider or Non-PPO emergency facility (regardless of the department of the hospital in which such items or services are furnished also includes post stabilization services (services after the patient is stabilized) and as part of outpatient observation or an inpatient or outpatient stay related to the emergency medical condition, until:

- The provider or facility determines that the participant or beneficiary is able to travel using nonmedical transportation or nonemergency medical transportation; and
- The participant or beneficiary is supplied with a written notice, as required by federal law, that the provider is a Non-PPO provider with respect to the Plan, of the estimated charges for your treatment and any advance limitations that the Plan may put on your treatment, of the names of any PPO providers at the facility who are able to treat you, and that you may elect to be referred to one of the participating providers listed; and
- The participant or beneficiary gives informed consent to continued treatment by the nonparticipating provider, acknowledging that the participant or beneficiary understands that continued treatment by the nonparticipating provider may result in greater cost to the participant or beneficiary.

Non-Emergency Items or Services from a Non-PPO Provider at a PPO Facility

With regard to non-emergency items or services that are otherwise covered by the Plan, if the covered non-emergency items or services are performed by a Non-PPO provider at a PPO facility, the items or services are covered by the plan:

- With a cost-sharing requirement that is no greater than the cost-sharing requirement that would apply if the items or services had been furnished by a PPO provider,
- By calculating the cost-sharing requirements as if the total amount that would have been charged for the items and services by such Non-PPO provider were equal to the Recognized Amount for the items and services.

- By counting any cost-sharing payments made by the participant or beneficiary toward any in-network deductible and in-network out-of-pocket maximums applied under the plan (and the in-network deductible and out-of-pocket maximums must be applied) in the same manner as if such cost-sharing payments were made with respect to items and services furnished by a PPO provider,
- Non-emergency items or services performed by a Non-PPO provider at a PPO facility will be covered based your out-of-network coverage if:

  - At least 72 hours before the day of the appointment (or three (3) hours in advance of services rendered in the case of a same-day appointment), the participant or dependent is supplied with a written notice, as required by federal law, that the provider is a Non-PPO provider with respect to the Plan, of the estimated charges for your treatment and any advance limitations that the Plan may put on your treatment, of the names of any PPO providers at the facility who are able to treat you, and that you may elect to be referred to one of the PPO providers listed; and
  - The participant or dependent gives informed consent to continued treatment by the Non-PPO provider, acknowledging that the participant or beneficiary understands that continued treatment by the Non-PPO provider may result in greater cost to the participant or beneficiary.

- The notice and consent exception does not apply to Ancillary services and items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished, regardless of whether the Non-PPO provider satisfied the notice and consent criteria, and therefore these services will be covered:

  - With a cost-sharing requirement that is no greater than the cost-sharing requirement that would apply if the items or services had been furnished by a PPO provider,
  - With cost-sharing requirements calculated as if the total amount charged for the items and services were equal to the Recognized Amount for the items and services, and

- With cost-sharing counted toward any in-network deductible and in-network out of pocket maximums, as if such cost-sharing payments were with respect to items and services furnished by a PPO provider.

Your cost sharing amount for Non-emergency Services at PPO Facilities by Non-PPO Providers will be based on the lessor of billed charges from the provider or the Qualifying Payment Amount.

Air Ambulance Services

If you receive Air Ambulance services that are otherwise covered by the Plan from a non-PPO provider, those services will be covered by the Plan as follows:

- The Air Ambulance services received from a Non-PPO provider will be covered with a cost-sharing requirement that is no greater than the cost-sharing requirement that would apply if the services had been furnished by a PPO provider.
- In general, you cannot be balance billed for these items or services. Your cost-sharing will be calculated as if the total amount that would have been charged for the services by a PPO provider of Air Ambulance services were equal to the lesser of the Qualifying Payment Amount or the billed amount for the services.
- Any cost-sharing payments you make with respect to covered Air Ambulance services will count toward your Network (PPO) deductible and Network (PPO) out-of-pocket maximum in the same manner as those received from a PPO provider.

Payments to non-PPO Providers and Facilities

The Plan will make an initial payment or notice of denial of payment for Emergency Services. Non-Emergency Services at PPO Facilities by Non-PPO Providers, and Air Ambulance Services within 30 calendar days of receiving a clean claim from the Non-PPO provider. The 30-day calendar period begins on the date the plan receives the information necessary to decide a claim for payment for the services.

If a claim is subject to the No Surprises Act, the participant cannot be required to pay more than the cost-sharing under the Plan, and the provider or facility is prohibited from billing the participant or dependent in excess of the required cost-sharing.

The Plan will pay a total plan payment directly to the non-PPO provider that is equal to the amount by which the Out-of-Network Rate for the services exceeds the cost-sharing amount for the services, less any initial payment amount.

External Review

An Adverse Benefit Determination that is related to an Emergency Service, Non-Emergency Service provided by a non-PPO provider at a PPO facility, and/or Air Ambulances services, as covered under the federal No Surprises Act, is eligible for External Review. Please see the External Review procedures in the SPD for further information.

Continuity of Coverage

If you are a Continuing Care Patient, and the contract with your Network provider or facility terminates, or your benefits under a group health plan are terminated because of a change in terms of the providers' and/or facilities' participation in the plan:

1. You will be notified in a timely manner of the contract termination and of your and of your right to elect continued transitional care from the provider or facility; and
2. You will be allowed up to ninety (90) days of continued coverage at Network cost sharing to allow for a transition of care to a Network provider.

This plan adheres to Covered for continued medical treatment ascribed under NRS 695G.164

Incorrect PPO Provider Information

A list of PPO providers is available to you without charge by visiting the website or by calling the phone number on your ID card. The network consists of providers, including hospitals, of varied specialties as well as general practice, who are contracted with the Plan or an organization contracting on its behalf.

If you obtain and rely upon incorrect information about whether a provider is a PPO provider from the Plan or its administrators, the Plan will apply PPO cost-sharing to your claim, even if the provider was Non-PPO.

Ambulance Services

Ambulance services are covered if the services are medically necessary, and they are:

- Provided in an emergency; or
- Provided in a non-emergency setting when prior authorized by the UM company.

Durable Medical Equipment (DME)

Coverage is provided for the purchase, rental, repair, or maintenance of durable medical equipment prescribed by a provider for a medically necessary condition other than kidney dialysis. **DME is limited to one purchase, repair, or replacement of a specific item of DME every 3 years.** Rental of DME to cover Medicare guidelines concerning rental to purchase criteria. The purchase or rental of DME more than $1,000 requires precertification from the UM company. Durable medical equipment is equipment that:

- Can withstand repeated use.
- Is not disposable.
- Is appropriate for use in the home.
- Is not useful in the absence of an illness or injury.
- Is prescribed by a physician.
- Meets CMS guidelines for coverage; and
- Is not primarily for convenience or comfort but serves a medical purpose.

Durable medical equipment includes, but is not limited to the following:

- Oxygen equipment (all oxygen and oxygen related equipment, except for oxygen while traveling on an airline),
- Wheelchairs,
- Hospital beds,
- Augmentation Devices,
- Glucose monitors, and
- Warning or monitoring devices for infants (defined as a child 24-months old or less) suffering from recurrent apnea.

Coverage will be based on an amount equal to the generally accepted cost of durable medical equipment that provides the medically necessary level of care at the lowest cost.

Items not covered under this benefit include, but are not limited to: dressings, any equipment or supply to condition the air, appliances, ambulatory apparatus, arch supports, support stockings, corrective footwear, orthotics or other supportive devices for the feet, heating pads, personal hygiene, comfort, care, convenience or beautification items, deluxe equipment, and any other primarily non-medical equipment, except as otherwise covered and described within this *Schedule of Medical Benefits* and the *Benefit Limitations and Exclusions* sections.

Also excluded are exercising equipment, vibratory or negative gravity equipment, swimming or therapy pools, spas, and whirlpools (even if recommended by your medical provider to treat a medical condition).

Enteral Formulas and Special Food Products

Enteral Formulas and Special Food Products are covered in accordance with NRS 689B.0353.

Documentation to substantiate the presence of an inherited metabolic disease, including documentation that the product purchased is a Special Food Product or Enteral Formula for the treatment of an inherited metabolic disease may be required before the Plan will reimburse for the costs associated with Special Food Products or Enteral Formulas.

Special formulas, food supplements, or special diets including, but not limited to, total parenteral nutrition, except for acute episodes, are not covered.

Hospice Services

The following hospice care services are covered for members with a terminally ill, limited life expectancy of six months. Additional days would have to be preauthorized by the UM Company. :

- Part-time intermittent home health care services totaling fewer than 8 hours per day and 35 or fewer hours per week
- Outpatient bereavement counseling of the participant and his or her immediate family (limited to 6 visits for all family members combined if they are not otherwise eligible for mental health benefits under their specific plan). Counseling must be provided by:
  - A psychiatrist.
  - A psychologist; or
  - A licensed, masters level clinician.
- Respite care providing nursing care for a maximum of 8 inpatient respite care days per Plan Year and 37 hours per Plan Year for outpatient respite care services. Inpatient respite care will be provided only when the UM company determines that home respite care is not appropriate or practical.

Lab and Diagnostic Services

Coverage is provided for medically necessary laboratory and diagnostic procedures, services, and materials, including:

- Diagnostic x-rays.
- Fluoroscopy.
- Electrocardiograms; and
- Laboratory tests.

Coverage is also provided for other laboratory and diagnostic screenings as well as provider services related to interpreting such tests.

Outpatient laboratory services are covered for pre-admission testing, urgent care, or emergency room. Pre-admission testing must be performed within 7 days of a scheduled hospital admission or outpatient surgery. The testing must be related to the sickness or injury for which admission or surgery is planned.

Outpatient laboratory services for routine/preventive lab testing must be performed at a non-hospital-based, freestanding laboratory such as Lab Corp or Quest.

If a freestanding, non-hospital-based laboratory facility is not available within 50 miles of your residence, you may use an in-network outpatient hospital facility or hospital-based lab draw station.

Routine lab services from independent labs may not be paid as wellness unless the TPA system finds a corresponding wellness office visit within a reasonable number of days prior or after lab date to validate wellness diagnosis.

2nd.MD Opinion

2nd.MD provides eligible members with direct access to elite specialists across the county for expert second opinions. Specialists answer questions about disease, cancer, chronic conditions, surgery or procedure, medications, and treatment plans. All specialists are board certified, leaders in research, and pioneers in medicine. To learn more visit *www.2nd.MD/PEBP* or call 1-866-841-2575.

Telemedicine or Telehealth (Doctor on Demand)

Telemedicine (virtual medicine) is available through Doctor on Demand. Participants can register with Doctor on Demand and connect face-to-face with a board-certified doctor, therapist or licensed psychologist on a smartphone, tablet, or computer through live video. Some of the medical and behavioral health conditions that may be treated include cold and flu, bronchitis, sinus issues, urinary tract infection, anxiety, depression, etc. Doctor on Demand providers can

also prescribe medications (except controlled substances). For more information, visit w*ww.pebp.state.nv.us* or the *Summary of Medical Benefits*.

Services available include:

- Medical visit
- Psychologist visit
- Psychiatry visit

You may receive services from a provider who is in a different location using information and audio-visual communication technology. Telemedicine does not include communication through telephone, facsimile, or email.

Doctor on Demand physicians do not prescribe DEA controlled substances and may elect not to treat or prescribe other medications based on what is clinically appropriate. In a true medical emergency, such as chest pains, shortness of breath or broken bones, dial 911 or seek immediate medical attention as appropriate.

Alternatively, telemedicine may be available from in-network providers and is covered on the same basis as in-person services. It is your responsibility to ensure the providers you use are in-network providers. Failure to use in-network providers will result in a denial of benefits and higher cost to you.

This Plan also adheres to the provisions of NRS 695G.162 regarding telehealth.

Continued Coverage Following Termination of a Provider Contract

For serious health conditions not covered by the No Surprises Act, if a participant is receiving a medically necessary course of treatment from an in-network provider and that provider leaves the network (except for termination due to medical incompetence or professional misconduct), and the participant and the provider agree that a disruption to the participant's current care may not be in the best interest or if continuity of care is not possible immediately with another in-network provider, this Plan will pay that provider at the same level they were being paid while contracted with this Plan's network, if the provider agrees. If the provider agrees to these terms, coverage may continue until:

- Such treatment is no longer medically necessary or no later than the 120th day after the date the contract is terminated; or
- If the medical condition is pregnancy, the 90th day after:
  - The date of delivery; or
  - If the pregnancy does not end in delivery, the date of the end of the pregnancy.

Transplants (Organ and Tissue)

Organ, bone marrow and tissue transplant coverage are provided only for eligible services directly related to non-experimental transplants of human organs or tissue, along with the facility and professional services, FDA-approved drugs, and medically necessary equipment and supplies.

This Plan will provide coverage for the donor when the recipient is a participant under this Plan. Coverage is provided for organ or tissue procurement and acquisition fees, including surgery, storage, and organ or tissue transport costs directly related to a living or nonliving donor (transport within the U. S. or Canada only). When the donor has medical coverage, his/her Plan will pay first and benefits under this Plan will be reduced by the amount payable under the donor's Plan.

Transplantation-related services require precertification (see the *Utilization Management* section of this document for details).

See the specific exclusions related to experimental and investigational services and transplants in the *Benefit Limitations and Exclusions* section.

This Plan provides for reimbursement of certain costs associated with travel and hotel accommodations for the patient and one additional person when the travels are associated with medical treatment for organ and tissue transplants performed at a Center of Excellence. Please refer to *Transplant Services* section for additional information. Expenses incurred for travel and hotel accommodations for organ and/or tissue transplants not performed at a Center of Excellence are not covered.

This Plan does not provide advance payment for travel expenses related to organ or tissue transplants.

See the specific exclusions related to experimental and investigational services and transplants in the *Benefit Limitations and Exclusions* section.

This Plan provides for reimbursement of certain costs associated with travel and hotel accommodations for the patient and one additional person when the travels are associated with medical treatment for organ and tissue transplants performed at a Center of Excellence. Please refer to *Schedule of Medical Benefits* section for additional information. Expenses incurred for travel and hotel accommodations for organ and/or tissue transplants not performed at a Center of Excellence are not covered.

This Plan does not provide advance payment for travel expenses related to organ or tissue transplants.

Use of Centers of Excellence for Transplant and Gastric (Bariatric) Procedures

This Plan requires participants to use an in-network Center of Excellence for transplant and bariatric weight/loss surgery. An appropriate Center of Excellence facility will be identified by the Plan's UM company and third-party Claims Administrator.

Travel

This Plan allows for the reimbursement of travel and hotel accommodation expenses permitted under IRS Regulation 213(d) and IRS Publication 502 for qualified medical expenses when the expenses are associated with the following services and have been pre-certified by the UM company:

- Organ and tissue transplants or bariatric weight loss surgery performed at a Center of Excellence; or
- Elective surgeries performed at exclusive hospitals/ambulatory facilities; and
- Outpatient infusion services if the UM company requires you to travel more than 50 miles one way for a service subject to precertification.
- Travel for a participant located in a State with restricted access to abortion to the nearest care center for abortion services covered under this Plan.

Participants are required to use the least expensive method of transportation. Participants who use their personal vehicle to travel to a Center of Excellence or to an exclusive hospital/ambulatory surgical facility or outpatient infusion center will be compensated for mileage from the participant's residence to and from the Center of Excellence or exclusive hospital/ambulatory surgical facility or outpatient infusion facility (based on an objective source such as Google Maps) at the standard mileage reimbursement rate for medical travel.

This Plan incorporates the travel expense reimbursement guidelines established in IRS Regulation 213(d) and IRS Publication 502.

NOTE: The Plan Administrator or its designee has full authority to approve or deny all or part of your travel expenses. The denial of travel expenses cannot be appealed.

Excluded Travel Expenses:

The following are specifically excluded from reimbursement under any circumstances (other expenses not included below may be denied if they are not preapproved):

- Alcoholic beverages.
- Car maintenance.
- Vehicle insurance.
- Flight insurance.
- Cards, stationery, stamps.
- Clothing.
- Dry cleaning.
- Entertainment (cable televisions, books, magazines, movie rentals).
- Flowers.

- Household products.
- Household utilities, including cell phone charges, house cleaner, baby-sitter, or day care services.
- Kennel fees.
- Laundry services.
- Meals (insomuch as it is excluded under the IRS Publication 502 and Regulations under 213(d).
- Security deposits.
- Toiletries.
- Travel expenses related to a facility or provider that is not a certified Center of Excellence, exclusive hospital/ambulatory surgical facility, or outpatient infusion facility; and
- Travel expenses incurred on or after one year following surgery are not eligible for reimbursement.
- Travel expenses are subject to the annual cost sharing requirements.

Note: PEBP will not reimburse travel or any other expense to any participant covered under PEBP's EPO Plan, the self-funded Consumer Driven Health Plan (CDHP), or the Low Deductible PPO Plan twice for any service or event.

PEBP does not provide advance payment for travel expenses.

Pre-Approval of your Travel Expenses

Unless there are extenuating circumstances, travel expenses must be pre-approved by PEBP or its designee. Travel expenses not pre-approved by PEBP or its designee will not be eligible for reimbursement.

If the participant is unable to obtain pre-approval by PEBP or its designee because the organ or tissue transplant required immediate travel, the participant may submit all associated travel costs to PEBP or its designee after the transplant surgery for consideration. The participant should designate someone to notify PEBP or its designee regarding the emergency travel and the circumstances surrounding such travel. Travel claims must be submitted within 12 months of the date of surgery to be considered eligible. All other requests for travel expenses require pre-approval.

Pre-approval will provide an approximation of your travel reimbursement. Final reimbursement will be based on actual expenses using the actual number of days and travel times and may differ from the pre-approved approximation. The Pre-approval Travel Expense Request form is available at www.pebp.state.nv.us.

Submitting your Travel Expense Receipts

A claim for travel expense reimbursement must be submitted to PEBP on a Travel Expense Reimbursement claim form. All relevant sections of the form must be completed including the

start and end times, destination, and purpose of trip. The claimant should sign the travel expense claim form attesting to the accuracy of the claim.

Travel expense reimbursement claims should be accompanied by original itemized receipts which include the name(s) of the person(s) incurring the expense.

Reimbursement of eligible travel expenses, including any eligible travel expenses relating to a travel companion, will be payable to the primary participant (employee or retiree) and not to the service vendor (credit card company, hotel, hospital, ~~restaurant,~~ etc.).

Schedule of Prescription Drug Benefits

Benefits for prescription drugs are provided through the prescription drug plan administered by Express Scripts. Coverage is provided only for those pharmaceuticals (drugs and medicines) approved by the U. S. Food and Drug Administration (FDA) as requiring a prescription and FDA approval for the condition, dose, route, duration, and frequency, if prescribed by a physician or other practitioner.

Some over the counter (OTC) drugs and prescription drugs are eligible to be covered under the Plan's Preventive Care Services benefit in accordance with the Affordable Care Act; whereby, the Plan will waive the Copay and Deductible and products are paid at 100%. Examples include aspirin, folic acid, smoking cessation products and female oral contraceptives. Please contact Express Scripts for more information.

Certain OTC female contraception products are covered when presented with a prescription from your physician to your pharmacy. These types of products include the female condom, sponges, and spermicides. Refer to the *Women's Preventive Care* section for more information or call Express Scripts, whose contact information is in the *Participant Contact Guide*.

Many vaccines may also be administered through the prescription drug benefit with certain pharmacies. Contact the pharmacy benefit manager listed in the *Participant Contact Guide* or visit *www.express-scripts.com* to check vaccine coverage and locate your nearest in-network pharmacy.

Coverage is also provided for, but not limited to:

- COVID-19 vaccinations and medications.
- Vaccinations such as shingles, HPV, Flu, pneumonia, Herpes Zoster, TDAP (tetanus, diphtheria, and pertussis -whooping cough)
- Prenatal & pediatric prescription vitamins
- Prescription female oral contraceptives
- Insulin, diabetic supplies (such as lancets, syringes, test strips), insulin pumps, and insulin pump supplies
    - Insulin pumps and supplies are covered under the pharmacy benefit's base day and quantity limits, subject to copayments, deductibles, or coinsurance.
- Orally Administered Chemotherapy: The Copayment or Coinsurance amount for orally administered chemotherapy drugs will be consistent with the drug's formulary tier for retail, home delivery and Specialty pharmacy; and in accordance with NRS 695G.167, the cost will not exceed $100 per prescription. For more information, see *Key Terms and Definitions* section.
- Chronic medication synchronization per NRS 695G.1665 .
- Topical Ophthalmic Products See also NRS 695G.172. Refills of topical ophthalmic products will be covered when medically necessary, including when requested: (a) After 21 days or more but before 30 days after receiving any 30-day supply of the product; (b) After 42 days or more but before 60 days after receiving any 60-day

supply of the product; or (c) After 63 days or more but before 90 days after receiving any 90-day supply of the product.

- Medically necessary prescription drugs to treat sickle cell disease and its variants (NRS 695G.174)
- Human Papillomavirus testing and vaccination under NRS 695G.171.

For helpful tools such as "Price a Medication" see the *Participant Contact Guide* section or go to the PEBP website at *www.pebp.state.nv.us.*

Preventive Drug Benefit Program

The Preventive Drug Benefit Program provides participants access to certain preventive drugs without having to meet a Deductible and will instead only be subject to Coinsurance. Coinsurance paid under the benefit will not apply to the Deductible but will apply to Out-of-Pocket Maximum costs. The medications covered under this benefit are limited to those preventive drugs identified by Express Scripts. Preventive drugs include categories of prescription drugs that are used for preventive purposes for conditions such as hypertension, asthma, and high cholesterol. A list of eligible preventive drugs covered under this benefit can be found by logging on to www.pebp.state.nv.us or by contacting Express Scripts located in the *Participant Contact Guide* section.

The plan adheres to NRS 695G.1715 regarding contraception and related health services.

Specialty Drugs

Specialty drugs are used to treat complex conditions, such as cancer, hemophilia, hepatitis C, immune deficiency, multiple sclerosis, rheumatoid arthritis, etc. Specialty drugs and prescriptions are limited to a 30-day supply. Specialty drugs must be filled through Accredo, an Express Scripts Specialty Pharmacy (see the *Participant Contact Guide)*. Plan participants are encouraged to register with the Accredo Specialty Pharmacy before filling their first prescription for a specialty drug. Check with Express Scripts to determine if your prescription is considered specialty.

Certain drugs fall into a category called specialty drugs. Specialty drugs are available only through the Specialty Pharmacy listed the *Participant Contact Guide* section, and prescriptions are limited to a 30-day supply. Plan participants are encouraged to register with the Specialty Pharmacy before filling their first prescription for a specialty drug. Contact Express Scripts to determine if your prescription is considered specialty.

Special pharmaceuticals, which include injectables, oral medications, and medications given by other routes of delivery, may be delivered in any setting. Special pharmaceuticals are pharmaceuticals that typically have:

- Limited access.
- Treat complex medical conditions.
- Complicated treatment regimens.

- Compliance issues.
- Special storage requirements; or
- Manufacturer reporting requirements.

This Plan's Pharmacy Benefit Manager maintains a list of special drugs classified as special pharmaceuticals. For information regarding special pharmaceuticals, contact the Pharmacy Benefit Manager listed in the *Participant Contact Guide*.

Copayment assistance (manufacturer-funded patient assistance) for specialty drugs will not apply toward your Deductible and Out-of-Pocket Maximum.

Preferred Retail Pharmacy Network

For short-term prescriptions, such as antibiotics, use a Preferred Retail Pharmacy (for lower copays) or a Non-Preferred Retail Pharmacy (where you will pay $10 extra for each short-term prescription). Your Preferred Retail Pharmacy Network has more than 34,000 pharmacies consisting of approximately 50% independent pharmacies in addition to grocers and other stores. To find a preferred pharmacy near you, register or log in to *express-scripts.com/findapharmacy* or call Express Scripts' Member Services at 855-889-7708.

Smart90 Retail and Home Delivery Program

The Smart90 program is a feature of your prescription plan, managed by Express Scripts. With this program, you have two ways to get up to a 90-day supply of your long-term medications (those you take regularly for ongoing conditions). You can fill your long-term prescriptions through home delivery from the Express Scripts Home Delivery Pharmacy or at a retail pharmacy in the Smart90 network.

You will need to move your long-term medications to both a 90-day supply and to either a participating retail pharmacy or Express Scripts Home Delivery Pharmacy. If, after your second 30-day supply courtesy fill of your long-term medication, you do not make the switch you will pay a higher cost for your prescription medication and will not receive credit toward your Deductible or Out-of-Pocket Maximum.

Smart90 Retail Pharmacy

To locate a participating Smart90 Retail Pharmacy or a Preferred Retail Network Pharmacy, log in to the E-PEBP Portal located at www.pebp.state.nv.us and select Express Scripts. You can also get pharmacy information by calling Express Scripts' Member Services at 855-889-7708. You can transfer your medications easily in-store, by phone or online.

Express Scripts Home Delivery

You may use home delivery through the Express Scripts Home Delivery Pharmacy to receive a 90-day supply of your maintenance medications and have them mailed to you with free standard

shipping. Not all drugs are available via mail order. Check with Express Scripts for further information on the availability of your prescription medication. Enrolling in home delivery is easy! First, log in to *express-scripts.com*.

If you are enrolling a new prescription in home delivery:

- **Contact your doctor** and ask them to e-prescribe a 90-day prescription directly to Express Scripts.
- **OR send a request** by selecting "Forms" or "Forms & Cards" from the "Benefits" menu, print and mail-order form and follow the mailing instructions.
- **OR call Express Scripts'** Member Services at 855-889-77058 and they will contact your doctor for you if you are enrolling a current prescription:

Transfer retail prescriptions to home delivery by **clicking "Add to Cart"** for eligible prescriptions and check out. You can also refill and renew prescriptions. Express Scripts will contact your doctor and take care of the rest.

Check **Order Status** to track the shipping of your prescriptions. After we receive your prescription from your doctor, you will receive your medication within 7 days. Please keep in mind, longer delivery times may be due to additional correspondence need with prescribers, medication availability and/or delivery times from the shipping vendor.

Generics Preferred Program

When your doctor prescribes a brand-name drug and a generic substitute is available, you will automatically receive the generic drug unless:

- Your doctor writes "dispense as written" (DAW) on the prescription; or
- You request the brand-name drug at the time you fill your prescription.

If you choose generic medicines, you get safe medicines at lower cost. Your copayment for the generic drug will be less than the copayment for the brand-name drug.

If a generic is available, but you or your doctor request the brand-name drug, you will pay the applicable brand copayment, plus the full difference in cost between the brand-name drug and the generic equivalent. This difference in cost is referred to as the ancillary fee. The ancillary fee is in addition to the copayment, so the cost could exceed the copayment maximum.

SaveonSP Program

As part of your prescription drug plan, Nevada Public Employees' Benefits Program has partnered with an Express Scripts' copay assistance program, SaveonSP, to help save money on certain specialty medications. Through the SaveonSP Program, manufacturer-funded assistance is

available to help assisting members with the cost of the Program drug(s) is reimbursed by the manufacturer at no cost to the participant.

The medications included in the SaveonSP Program are classified as Non-Essential Health Benefits under the Affordable Care Act. The cost of these drugs will not be applied towards satisfying your deductible or out-of-pocket maximum.

Members currently taking a medication or those who will be taking a medication that is on the Non-Essential Benefit Specialty Drug List, are eligible to participate in the program.

- Select medications on the *Non-Essential Benefit Specialty Drug List* will be free of charge ($0) to members who participate.
- Prescriptions must be filled through Accredo Specialty Pharmacy.
- The medications and associated copays included in this program are subject to the Pharmacy Benefit Manager's clinical rules.
- If the medication you are taking is on the SaveOnSP *Non-Essential Benefit Specialty Drug List* and you wish to participate, call SaveOnSP at 1-800-683-1074.
- The SaveonSP Program drug list can be found at *www.saveonsp.com/pebp*

Participation in the SaveOnSP Program is voluntary; however, if you are taking or will be taking a medication that is on the Non-Essential Benefit Specialty Drug List, and you choose not to participate in the SaveOnSP Program, you will be responsible for the copay outlined in the SaveonSP Program Drug List and that cost will not apply toward your Deductible or Out-of-Pocket Maximum.

Hinge Health Digital Musculoskeletal (MSK) Care program

Hinge Health's Digital MSK Program is offered through Express Scripts' and is designed to help members with Musculoskeletal Care using digital technology. The program offers qualifying participants virtual physical therapy focusing on prevention, acute injury, chronic and surgical care programs via digital physical therapy plus additional physical and behavioral support through a full clinical-care team. Members will also have access to other services, such as, pelvic floor therapy, advanced wearable technology for electrical nerve stimulation and pain relief, expert medical opinion consultation, health education, etc.

Members will complete a screener to assess which Digital MSK ClinicTM programs is right for them. The questionnaire screener leverages data analytics combined with a dedicated clinical care team review to match each member's personal needs with the right program tools and resources. This program is managed by Express Scripts and is provided at no cost to members.

Extended Absence Benefit

If you are going to be away from your home for an extended period, either in the country or outside of the country, you may obtain an additional fill (30 or 90-day supply) of your prescription drugs from your local retail or mail order pharmacy. This limited benefit must be requested in

advance by the participant to the pharmacy benefit manager listed in the *Participant Contact Guide*. A maximum of two (2) early refills are allowed every 180 days. You may be required to obtain a new written prescription from your physician and any necessary prior authorizations.

Out-of-Country Emergency Medication Purchases

This Plan may cover emergency prescription drugs purchased if you reside in the United States and travel to a foreign country. You will need to pay for the drug at the time of purchase and later submit for reimbursement from the Pharmacy Benefit Manager. Prescription drug purchases made outside of the United States are subject to Plan provisions, limitations and exclusions, clinical review, and determination of medical necessity. The review will also include regulations determined by the FDA. Out-of-Country medication purchases are only eligible for reimbursement while traveling outside of the United States.

If your purchase is eligible for reimbursement, you must use the Direct Claim Form available from the prescription drug plan administrator. Direct Claim Forms may be requested from the prescription drug plan or obtained by logging in to *www.express-scripts.com*. In addition to the Direct Claim Form, you are required to provide:

- A legitimate copy of the written prescription completed by your physician.
- Proof of payment from you to the provider of service (typically your credit card invoice).
- Prescription and receipt must be translated to English and include the American equivalent National Drug Code for the prescription purchased.
- Reimbursement request must be converted to United States dollars.

The claim will be processed based on the American equivalent National Drug Code and charged based upon that drug copay tier. If an American equivalent National Drug Code does not exist, the claim will be denied.

Any foreign purchases of prescription medications will be subject to Plan limitations such as:

- Benefits and coverage
- Deductibles
- Coinsurance
- Dispensing maximums
- Annual benefit maximums
- Medical Necessity
- Usual and Customary (U&C) or prescription drug pharmacy benefit manager contracted allowable
- FDA approval
- Plan prior authorization requirements

Contact the Express Scripts before traveling or moving to another country to discuss any criteria that may apply to a prescription drug reimbursement request.

Out-of-Network Pharmacy Benefit

Prescriptions filled at a domestic (inside the United States) out-of-network pharmacy location, are not authorized for reimbursement under the prescription drug Plan. Prescription drugs must be filled at a participating in-network pharmacy location.

Other Limitations:

- This Plan does not coordinate prescription drug plan benefits with other prescription drug plans. It is the participant's responsibility to use the appropriate primary and secondary (if applicable) prescription plan.
- See exclusions related to medications in the *Exclusions* section of this document.
- The formulary is maintained by the Pharmacy Benefit Manager and may be subject to change according to the Pharmacy Benefit Manager.

Benefit Limitations and Exclusions

This Plan does not cover certain services. This chapter lists the general medical and pharmacy benefit exclusions of this Plan. Any amount you pay toward services that are not covered or otherwise excluded will not count toward your out-of-pocket maximum. Additional exclusions that apply to only a service or benefit are listed in the description of that service or benefit in the *Summary of Medical Benefits* and *Schedule of Medical Benefits* sections. This list is not all-inclusive; if you have questions about a service or supply, contact the Claims Administrator listed in the *Participant Contact Guide.*

Expenses That Do Not Accumulate Toward Your Out-of-Pocket Maximum

The following services do not accumulate toward the out-of-pocket maximum, and you will be responsible for paying these expenses out of your own pocket.

- All expenses for medical and pharmacy services and supplies that are not covered by the Plan, to include but not limited to, expenses that exceed the LD network contract rate, services listed in the *Benefit Limitations and Exclusions* section.
- All charges in excess of the usual and customary charge determined by the Plan Administrator.
- Any additional amounts you must pay because you failed to comply with the utilization management requirements described in the *Utilization Management* section.
- Benefits exceeding those services or supplies subject to maximum individual or lifetime limit(s) for certain eligible medical expenses as listed in the *Schedule of Medical Benefits*; and
- Certain wellness or preventive services that are paid by this Plan at 100% do not accumulate towards the out-of-pocket maximum.

This list is not all inclusive and may not include certain services and supplies that are not listed above.

Benefit Limitations

In addition to the exclusions listed below, refer to the *Summary of Medical Benefits* and *Schedule of Medical Benefits* sections for the maximum individual or lifetime limit(s) and any Plan Year limit applicable to certain covered expenses. Plan Year limits are met by days, hours, visits, or dollar limits paid under all components of the Plan.

Lifetime Maximum

This Plan imposes a lifetime maximum on some health care services and procedures. For information on the lifetime maximums, refer to the *Summary of Medical Benefits* and *Schedule of Medical Benefits* sections.

Exclusions Under the Medical Plan

The following is a list of services and supplies or expenses not covered by this Plan. The Plan Administrator and its designees will have discretionary authority to determine the applicability of these exclusions and terms of the Plan and determines eligibility and entitlement to Plan benefits. Any amount you pay toward services that are not covered or otherwise excluded will not count toward your out-of-pocket maximum.

Abortion: Termination of pregnancy is excluded, other than medically indicated abortions that are medically necessary to save the life of the mother and complications of such abortions.

Alternative/Complimentary Health Care: Expenses for chelation therapy, except as may be medically necessary for treatment of acute arsenic, gold, mercury, or lead poisoning, and for diseases due to clearly demonstrated excess of copper or iron. Expenses for prayer, religious or spiritual healing or counseling. Expenses for homeopathic treatments/supplies that are not FDA approved. See the *Summary of Medical Benefits* and *Schedule of Medical Benefits* for benefit limitations and copayments and cost-sharing.

Autopsy: Expenses for an autopsy and any related expenses, except as required by the Plan Administrator or its designee.

Bariatric and Overweight Surgery: The Plan's individual lifetime maximum is one (1) bariatric surgery while covered under any current or previous PEBP self-funded health plan.

Bariatric and Overweight Surgery not Performed at a Center of Excellence Provider: Benefits are excluded for bariatric/weight loss surgery performed at an out-of-network facility, out-of-network surgeon, or out-of-network ancillary provider are used, unless covered under the No Surprises Act. PEBP or its designee will determine the in-network Center of Excellence facility.

Behavioral (Mental) Health Services

- Expenses for hypnosis and hypnotherapy.
- Expenses for behavioral health care services related to: adoption counseling; non medically necessary court-ordered behavioral health care services (except pursuant to involuntary confinement under a state's civil commitment laws); custody counseling; dance/poetry/art therapy, developmental disabilities; dyslexia, learning disorders; attention deficit disorders (with or without hyperactivity, except when the services are for diagnosis, the prescription of medication as prescribed by a physician or other health care practitioner, or when accompanied by a treatment plan as submitted to the Plan or its designee) or the treatment is related to the management of ADD/ ADHD without prescription drugs and is approved by the Plan or its designee; family planning counseling; marriage/couples/and/or sex counseling; intellectual disability; pregnancy counseling; vocational disabilities, and organic and non-organic therapies including (but not limited to) crystal healing/EST/primal therapy/L-Tryptophan/vitamin therapy, religious/spiritual, etc.

- Expenses for tests to determine the presence of or degree of a person's dyslexia or learning disorder unless the visit meets the criteria for benefits payable for the diagnosis or treatment of autism spectrum disorder.

Complications of a non-covered service: Expenses for care, services or treatment required because of complications from treatment or medications are not covered under this Plan, except complications from an abortion.

Concierge membership fees: Expenses for fees described or defined as membership, retainer or premiums that are paid to a concierge medical practice to have access to the medical services provided by the concierge medical practice.

Controlled Substance or Intoxicated: Services/treatment which involve an injury to which a contributing cause was the insured's commission of or attempt to commit a felony, except if a result of a medical or behavioral health condition, or domestic violence, even if the condition was not diagnosed at the time of the injury. See NRS 695G.405.

Corrective Appliance, Orthotic Device Expenses, and Appliances: Any items that are not corrective appliances, orthotic devices or orthotic braces that straighten or change the shape of a body part, prosthetic appliances, or durable medical equipment (as each of those terms is defined in the *Key Terms and Definitions s*ection), including, but not limited to, personal comfort items like air purifiers, humidifiers, electric heating units, swimming pools, spas, saunas, escalators, lifts, motorized modes of transportation, pillows, orthopedic mattresses, water beds, and air conditioners are excluded. Expenses for cranial helmets are excluded except for cranial helmets used to facilitate a successful post-surgical outcome. Expenses for replacement of lost, missing, or stolen, duplicate or personalized corrective appliances, orthotic devices, prosthetic appliances, or durable medical equipment are not covered. Oxygen provided while traveling on an airline and portable oxygen concentrators that are supplied for purchase or rent specifically to meet airline requirements are excluded.

Cosmetic Services and Surgery: The Plan excludes expenses for cosmetic services and surgery or any drugs used for cosmetic purposes, including but not limited to health and beauty aids unless explicitly noted in the Covered Services section.

Complications resulting from Cosmetic Services or Surgery are not covered.

There is no coverage for travel costs.

Costs of Reports, Bills, etc.: Expenses for preparing medical reports, bills or claim forms; mailing, shipping, or handling expenses; and charges for broken/missed appointments, general telephone calls not including telehealth, or photocopying fees.

Court-Ordered Treatment: Medical and psychiatric evaluations, examinations, or treatments, psychological testing, therapy, laboratory and other diagnostic testing and other services

including hospitalizations or partial hospitalizations and residential treatment programs that are ordered as a condition of processing, parole, probation, or sentencing are excluded, unless the Plan Administrator or its designee determines that such services are independently medically necessary.

Custodial Care: Expenses for custodial care as defined in the Key Terms and Definitions section, regardless of where they are provided, including, without limitation, adult day care, child day care, services of a homemaker, or personal care, sitter/companion service, including any service that can be learned to be performed or provided by a family member who is not a physician, nurse or other skilled health care provider are not covered, even if they are medically necessary.

Services required to be performed by physicians, nurses or other skilled health care providers are not considered to be provided for custodial care services and are covered if they are determined by the Plan Administrator or its designee to be medically necessary. However, any services that can be learned to be performed or provided by a family member who is not a physician, nurse or other skilled health care provider are not covered, even if they are medically necessary.

Dental Services: Expenses for dental prosthetics or dental services or supplies of any kind, even if they are necessary because of symptoms, congenital anomaly, illness, or injury affecting the mouth or another part of the body.

Except as described as an inclusion in the *Schedule of Medical Benefits*, services involving treatment to the teeth; extraction of teeth; repair of injured teeth; general dental services; treatment of dental abscesses or granulomas; treatment of gingival tissues (other than for tumors); dental examinations; restoration of the mouth, teeth, or jaws because of injuries from biting, chewing, or accidents; artificial implanted devices; braces; periodontal care or surgery; teeth prosthetics and bone grafts regardless of etiology of the disease process; and repairs and restorations except for appliances that are medically necessary to stabilize or repair sound and natural teeth after an injury; dental and or medical care including mandibular or maxillary surgery, orthodontia treatment, oral surgery, pre-prosthetic surgery, any procedure involving osteotomy to the jaw, and any other dental product or service except as set forth in the *Schedule of Medical Benefits*.

Coverage for dental services as the result of an injury to teeth may be extended under the medical Plan to a maximum of two (2) years following the date of the injury. Restorations past the two-year time frame will be considered under the dental benefits described in the PEBP Self-Funded Dental PPO Plan Master Plan Document available at www.pebp.state.nv.us.

Treatment to the gums and treatment of pain or infection known or thought to be due to dental or medical cause and in close proximity to the teeth or jaw, braces, bridges, dental plates or other dental orthosis or prosthesis, including the replacement of metal dental fillings; and other supplies and services including but not limited to cosmetic restorations, implants, cosmetic replacements of serviceable restorations, and materials (such as precious metals).

Orthodontia is a specific Plan exclusion.

Drugs, Medicines, Nutrition or Devices Exclusions:

- Pharmaceuticals requiring a prescription that have not been approved for use by the U.S. Food and Drug Administration (FDA); have not been prescribed for a medically necessary indication or are experimental and/or investigational (as defined in the *Key Terms and Definitions* section of this document).
- Non-Prescription (non-legend or over the counter) drugs or medicines (except as preventive care medications required by the Affordable Care Act).
- Foods and nutritional/dietary supplements including (but not limited to) home meals, formulas, foods, diets, vitamins, herbs, and minerals (whether they can be purchased over the counter or require a prescription), except when provided during hospitalization; prenatal vitamins or minerals requiring a prescription.
- Special Food Product (as defined in the Key Terms and Definitions section), except for the benefit described as covered under Special Food Product in the Schedule of Medical Benefits section or elsewhere in this document
- Naturopathic, Naprapathic, or homeopathic treatments/substances.
- Weight control or anorexiants (phentermine, Xenical, HCG, including the OTC weight loss products), except those anorexiants used for treatment of children with attention deficit hyperactivity disorder (ADHD) or individuals with narcolepsy.
- Compounded prescriptions in which there is not at least one ingredient that is a Legend Drug requiring a prescription, as defined by federal or state law.
- Take-home drugs or medicines provided by a hospital, emergency room, ambulatory surgical facility/center, or other health care facility.
- Vaccinations, immunizations, inoculations, or preventive injections that are not covered under the *Summary of Medical Benefits* section.
- Marijuana and any derivative, including CBD, THC, edibles, etc. are not a covered benefit under this Plan.
- Non-prescription devices and drugs purchased from retail or mail-order pharmacies are not payable under the *Prescription Drug Program*.
- Drugs to enhance athletic performance such as anabolic steroids (including off-labeled growth hormone). Coverage for human growth hormone or equivalent is excluded unless specifically covered and described in the *Summary of Medical Benefits*.
- Non-prescription male contraceptives, e.g., condoms.
- Dental products such as topical fluoride preparations and products for periodontal disease, except as a preventive service required under the Affordable Care Act.
- Hair removal or hair growth products (*i.e.,* Propecia, Rogaine, Minoxidil, Vaniqa).
- Vitamin A derivatives (retinoids) for dermatologic use.
- Vitamin B-12 injections (except for pernicious anemia, other specified megaloblastic anemias not elsewhere classified, anemias due to disorders of glutathione metabolism, post-surgery care or other b-complex deficiencies), antihemophilic factors including tissue plasminogen activator (TPA), acne preparations, and laxatives (unless otherwise specified in the *Schedule of Medical Benefits*.
- Anti-aging treatments (even if FDA-Approved for other clinical indications).

Durable Medical Equipment Exclusions:
See the exclusions related to Corrective Appliance, Orthotic Device Expenses, and Appliances

Educational Services: Expenses for educational/vocational services, supplies or equipment including (but not limited to) computers, software, printers, books, tutoring, visual aids, auditory aides, and speech aides, programs to assist with auditory perception or listening/learning skills, programs/services to remedy or enhance concentration, memory, motivation, or self-esteem, etc. (even if they are required because of an injury, illness, or disability of a covered individual).

Electronic cigarettes: The Plan does not cover electronic cigarettes.

Employer-Provided Services: Expenses for services rendered through a medical department, clinic or similar facility provided or maintained by you or your covered dependents' employer; or for benefits otherwise provided under this Plan or any other Plan that PEBP contributes to or otherwise sponsors (e.g., HMOs).

Expenses Exceeding Maximum Plan Benefits: Expenses that exceed any Plan benefit limitation or Plan Year maximum benefit as described in this document.

Expenses Exceeding Usual and Customary Charges, Maximum Allowable Charge, Prevailing Rates and Plan Contracted Rates: Any portion of the expenses for covered medical services or supplies that are determined by the Plan Administrator or its designee to exceed the Plan's Maximum Allowable Charge, usual and customary charge, prevailing rates or Plan contracted rate as defined in the *Key Terms and Definitions* section, except as required by independent dispute resolution under the No Surprises Act .

Expenses for Which a Third Party Is Responsible: See "Third-Party Liability" of the Health and Welfare Wrap document that can be found on www.pebp.state.nv.us (NAC 287.755)**.**

Expenses Incurred Before or After Coverage: Expenses for services rendered or supplies provided either before the patient became covered under the medical program or after the date the patient's coverage ends, except under those conditions described in COBRA.

Experimental and/or Investigational Services: Unless mandated by law, expenses for any medical services, supplies, drugs, or medicines that are determined by the Plan Administrator, UM company, or its designee to be experimental and/or investigational services.

Fertility and Infertility Services: Except as otherwise specified in the *Schedule of Medical Benefits* section, all other costs incurred for reproduction by artificial means or assisted reproductive technology (such as in-vitro fertilization, or embryo transplants) ~~except services directly related to artificial insemination services up to the maximum benefit limit are excluded~~. This exclusion includes treatments, testing, services, supplies, devices, or drugs intended to produce a pregnancy; the promotion of fertility including, but not limited to, fertility testing (except as

otherwise covered and described above); serial ultrasounds; services to reverse voluntary surgically-induced infertility; reversal of surgical sterilization; any service, supply, or drug used in conjunction with or for the purpose of an artificially induced pregnancy, test-tube fertilization; the cost of donor sperm or eggs; in-vitro fertilization and embryo transfer or any artificial reproduction technology or the freezing of sperm or eggs or storage costs for frozen sperm, eggs, or embryos; including, but not limited to, determining, evaluating, or enhancing the physical or psychological readiness for pregnancy, procedures to improve the participant's ability to become pregnant or to carry a pregnancy to term; and any payment made by or on behalf of a participant who is contemplating or has entered into a contract for surrogacy to a provider or individual related to any services potentially included in the scope of surrogacy services; sperm donor for profit or prescription (infertility) drugs; or GIFT or ZIFT procedures, low tubal transfers, or donor egg retrieval are also excluded.

Foot/Hand Care
Expenses for non-symptomatic foot care such as the removal of warts (except plantar warts); corns or calluses; and including but not limited to podiatry treatment of bunions, toenails, flat feet, fallen arches, and chronic foot strain; and expenses for routine foot care (including but not limited to: trimming of toenails, removal of corns and callouses, preventive care with assessment of pulses, skin condition and sensation) or hand care, (including manicure and skin conditioning), unless the Plan Administrator or its designee determines such care to be medically necessary.

Routine foot care from a podiatrist for treatment of foot problems such as corns, calluses and toenails are payable for individuals with a metabolic disorder such as diabetes, or a neurological or peripheral-vascular insufficiency affecting the feet.

Gender Dysphoria and/or Gender Services: Certain procedures associated with gender dysphoria treatment and/or gender surgery found to be non-medically necessary in the Treatment for Gender Dysphoria section above and are not covered.

- No more than one genital surgery in the individual's lifetime covered under any current or previous PEBP health plan.
- There is no coverage for travel costs.
- A surgery to reverse a surgery to treat gender dysphoria will not be covered.

Genetic Testing and Counseling: Coverage is not available for tests solely for research, or for the benefit of individuals not covered under this Plan.

Expenses for genetic testing and counseling are excluded, unless otherwise specified in this Plan's *Schedule of Medical Benefits*.

Gym Fees: Fees by personal trainers or gym or health club memberships, exercise programs, or exercise physiologists, even if recommended by a professional to treat a medical condition.

Hair: Expenses for or related to hair removal, hair transplants and other procedures to replace lost hair or to promote the growth of hair, including prescription and non-prescription drugs such as Minoxidil, Propecia, Rogaine, Eflornithine; or for hair replacement devices, including (but not limited to) wigs, toupees and/or hairpieces or hair analysis. Patients undergoing chemotherapy may be able to receive benefits for some hair replacement devices, as listed above

Hearing Care: Special education and associated costs in conjunction with sign language education for a patient or family members.

Hearing Aids: Over the Counter hearing aids are excluded from the Plan.

Home Birth/Delivery: Planned birth/delivery at home and associated services are not covered by this Plan. Guidelines for Perinatal Care published by the American Academy of Pediatrics and American College of Obstetricians and Gynecologists (ACOG) that the hospital, including a birthing center within the hospital complex, or a freestanding birthing center, provides the safest setting for labor, delivery, and the postpartum period. The use of other settings is not covered by this Plan. Facilities providing obstetrical care should have the services listed as essential components of a Level 1 hospital.

Home Health Care:

- Expenses for any home health care services that are not medically necessary, other than part-time, intermittent skilled nursing services and supplies.
-
- Expenses for a homemaker, custodial care, childcare, adult care, or personal care attendant, except as provided under the Plan's hospice coverage.
- Expenses for any home health care services that is not provided by an organization or professional licensed by the state to render home health services.
- Over-the-counter medical equipment supplies or any prescription drugs, except otherwise provided in the *Summary of Medical Benefits* and *Schedule of Medical Benefits*.
- Expenses for any services provided substantially or primarily for the participant's convenience or the convenience of a caregiver.

Hospital Employee, Medical Students, Interns or Residents: Expenses for the services of an employee of a hospital, skilled nursing facility or other health care facility, when the facility is obligated to pay that employee.

1.

Illegal Act: Expenses incurred by any covered participant for injuries resulting from commission (or attempted commission by the covered participant) of an illegal act the Plan Administrator determines involved violence or the threat of violence to another person, or in which any weapon or explosive is used by the covered participant, unless such injury is the result of a physical or mental health condition or domestic violence. The Plan Administrator's determination that this

exclusion applies shall not be affected by any prosecution, or acquittal of (or failure to prosecute) the covered participant in connection with the acts involved.

Internet/Virtual Office Visit: Expenses related to an online internet consultation with an out-of-network physician or other health care practitioner (also called a virtual office visit/consultation), physician-patient web service or physician-patient e-mail service (including receipt of advice, treatment plan, prescription drugs or medical supplies obtained) from an online internet provider who is not a participating provider in the Plan network except as specifically provided.

Maternity/Family Planning:

- Contraception: Expenses related to prescription or non-prescription male contraceptive drugs and devices such as condoms.
- Termination of Pregnancy: Expenses for elective termination of pregnancy (abortion) unless the attending physician certifies the health of the mother would be endangered if the fetus were carried to term, and complications of such termination.
- Childbirth courses.
- Expenses related to delivery associated with a pregnant dependent child, except for expenses related to complications of pregnancy.
- Expenses related to cryo-storage of umbilical cord blood or other tissue or organs.
- For nondurable supplies.
- Reversal of prior sterilization procedures, including, but not limited to tubal ligation and vasectomy reversals.
-

Medically Unnecessary Services: Services or supplies determined by the Plan Administrator or its designee not to be medically necessary, as defined in the *Key Terms and Definitions* section.

Modifications of Homes or Vehicles: Expenses for construction or modification to a home, residence or vehicle required because of an injury, illness, or disability of a participant, including, without limitation, any construction or modification (e.g., ramps, elevators, chair lifts, swimming pools, spas, air conditioning, asbestos removal, air filtration, handrails, emergency alert system, etc.)

No-Cost Services: Expenses for services rendered or supplies provided without cost, or for which there would be no charge if the person receiving the treatment were not covered under this Plan.

No Provider Recommendation or Order: Expenses for services rendered or supplies provided that are not recommended or prescribed by a physician or other licensed provider acting within the scope of their license.

Non-Emergency Hospital admission: Care and treatment billed by a hospital for a non-medical emergency admission on a Friday or Saturday unless surgery is performed within 24 hours of the admission.

Non-Emergency Travel and Related Expenses: Expenses for and related to non-emergency travel or transportation (including lodging, meals, and related expenses) of a health care provider, participant except where otherwise specified in the *Utilization Management* section for organ/ tissue transplants and bariatric weight loss surgery or certain surgeries performed in a surgery center, inpatient hospital or outpatient setting as determined by the Plan Administrator or the UM company.

Occupational Illness, Injury or Conditions Subject to Workers' Compensation: All expenses incurred by you or any of your covered dependents arising out of or during employment if the injury, illness, or condition is subject to coverage, in whole or in part, under any Workers' Compensation, or occupational disease (or similar) law.

Orthodontia: Expenses for any services relating to orthodontia evaluation and treatment even if the orthodontia services are provided as the result of an accident or medical condition.

Personal Comfort Items: Expenses for patient convenience, including (but not limited to) care of family members while the participant is confined to a hospital (or other health care facility, or to bed at home), guest meals, television, VCR/DVD, telephone, barber or beautician services, house cleaning or maintenance, shopping, birth announcements, photographs of new babies, etc.

Private Room in a Hospital or Health Care Facility: The use of a private room in a hospital or other health care facility, unless the facility has only private room accommodations, or unless the use of a private room is certified as medically necessary by the Plan Administrator or its designee.

Prophylactic Surgery or Treatment: Unless otherwise noted in this document, expenses for medical or surgical services or procedures, including prescription drugs and the use of prophylactic surgery (as defined in the *Key Terms and Definitions* section), when the services, procedures, Prescription of Drugs, or Prophylactic surgery is prescribed or performed for:

- Avoiding the possibility or risk of an illness, disease, physical or mental disorder or condition based on family history and/or genetic test results, in certain circumstances; or
- Treating the consequences of chromosomal abnormalities or genetically transmitted characteristics when there is an absence of objective medical evidence of the presence of disease or physical or mental disorder. Participants should use the Plan's UM company to assist in the determination of a proposed surgery to determine if it is or is not covered under this Plan.

NOTE: Some prophylactic surgeries may be covered under this Plan if certain criteria are met. Please refer to the *Schedule of Medical Benefits* section. For additional information, please contact this Plan's UM company or Claims Administrator.

Prophylactic drugs are excluded.

1.

Rehabilitation Therapy (Inpatient or Outpatient):

- Expenses for educational, job training, vocational rehabilitation, and/or special education for sign language.
- Expenses for massage therapy, Rolfing, and related services.
- Expenses incurred at an inpatient rehabilitation facility for any inpatient rehabilitation therapy services provided to an individual who is unconscious, comatose, or in the judgment of the Plan Administrator or its designee, is otherwise incapable of conscious participation in the therapy services and/or unable to learn and/or remember what is taught, including (but not limited to) coma stimulation programs and services.
- Expenses for maintenance rehabilitation, as defined in the *Key Terms and Definitions* section.
- Expenses for speech therapy for functional purposes including (but not limited to) stuttering, stammering and conditions of psychoneurotic origin.
- Expenses for cognitive therapy are excluded unless related to short-term services necessitated by a catastrophic neurological event to restore functioning for activities of daily living.
- Therapies, psychological services, counseling, or tutoring services for developmental delay or learning disability.
- Treatment that a federal or state law mandates that coverage be provided and paid for by a school district or other governmental agency.

Service Animals: Expenses for the purchase, training, or maintenance of any type of service animal, even if designated as medically necessary.

Smoking Cessation or Tobacco Withdrawal: Expenses for non-prescription (over the counter) tobacco/smoking cessation products such as nicotine gum or patches, unless prescribed by a physician. There are no benefits payable for the use of electronic cigarettes. Prescription smoking/tobacco cessation products are payable under the prescription drug benefit as described in the *Schedule of Medical Benefits* section.

Stand-By Physicians or Health Care Practitioners: Expenses for any physician or other health care provider who did not directly provide or supervise medical services to the patient, even if the physician or health care practitioner was available on a stand-by basis.

Telephone Calls: Expenses for all telephone calls between a physician or other health care provider and any patient, other health care provider, UM company or vendor; or any representative of this Plan for any purpose whatsoever.

Transplant (Organ and Tissue):

- Expenses for human organ and/or tissue transplants that are experimental and/or Investigational, including (but not limited to) donor screening, acquisition and selection, organ or tissue removal, transportation, transplants, post-operative services and drugs or medicines, and all complications thereof, except those transplant services as described under Transplants in the *Schedule of Medical Benefits*.
- Expenses related to non-human (Engrafted) organ and/or tissue transplants or implants, except heart valves.
- Expenses incurred by the person who donates the organ or tissue, unless the person who receives the donated organ/tissue is the person covered by this plan.

Travel Outside of the United States: Any services received outside the United States are excluded unless deemed to be urgent or emergency care.

Urgent Care: Any urgent care services that are received out-of-network are excluded unless the urgent care service is received out-of-area as defined in the *Key Terms and Definitions*.

Vision Care: Charges for the fitting and cost of visual aids, vision therapy, eye therapy, orthoptics with eye exercise therapies, refractive errors including but not limited to eye exams and surgery done in treating myopia (except for corneal graft); ophthalmological services provided in connection with the testing of visual acuity for the fitting for eyeglasses or contact lenses, eyeglasses or contact lenses (except coverage for the first pair of eyeglasses or contact lenses following cataract surgery); and surgical correction of near or far vision inefficiencies such as laser and radial keratotomy are excluded, except as otherwise specified in this Plan's *Summary of Medical Benefits* and *Schedule of Medical Benefits.*

War or Similar Event: Expenses incurred because of an injury or illness due to a participant's participation in any act of war, either declared or undeclared, war-like act, riot, insurrection, rebellion, or invasion, except as required by law.

Weight Management and Physical Fitness:

- Medical or surgical treatment for weight-related disorders including (but not limited to) surgical interventions, dietary programs, and prescription drugs, except those services specified in the *Summary of Medical Benefits* and *Schedule of Medical Benefits*. Surgery for weight reduction must be performed at a Bariatric Center of Excellence. Expenses for weight loss surgery performed without a precertification from the UM company will be denied.

- Expenses related to programs such as Weight Watchers, Jenny Craig, Nutri-Systems, Slim Fast or the rental or purchase of any form of exercise equipment.
- Expenses for medical or surgical treatment of severe underweight, including (but not limited to) high calorie and/or high protein food supplements or other food or nutritional supplements, except in conjunction with medically necessary treatment of anorexia, bulimia, or acute starvation. Severe underweight means a weight more than 25 percent under normal body weight for the patient's age, sex, height, and body frame based on weight tables generally used by physicians to determine normal body weight.
- Expenses for memberships in or visits to health clubs, exercise programs, gymnasiums, and/or any other facility for physical fitness programs, including exercise equipment.
- One obesity related surgery per lifetime while covered under any PEBP self-funded medical Plan (e.g., LD PPO Plan, CDHP and EPO Plan).

Other Benefit Exclusions

- Stress reduction therapy or cognitive behavior therapy for sleep disorders.
- Sleep therapy (except for central or obstructive apnea when medically necessary and when a precertification has been received from the UM company), behavioral training or therapy, milieu therapy, biofeedback (unless included with psychotherapy), behavior modification, sensitivity training, hypnosis, electro hypnosis, electro-sleep therapy, electro-narcosis, massage therapy, and gene therapy.
- Charges that result from appetite control, food addictions, or any treatment of obesity, unless otherwise provided in the *Summary of Medical Benefits* and *Schedule of Medical Benefits.*
- Except as otherwise provided in the *Summary of Medical Benefits* and *Schedule of Medical Benefits*, drugs, medicines, procedures, services, and supplies to correct or enhance erectile function, enhance sensitivity or for sexual dysfunction (organic or inorganic), inadequacy, or enhancement, including penile implants and prosthetics, injections, and durable medical equipment.
- Aroma therapy, massage therapy, reiki therapy, thermograph, orthomolecular therapy, contact reflex analysis, Bio-Energetic Synchronization Technique (BEST), colonic irrigation, magnetic innervation therapy and electromagnetic therapy.
- Natural and herbal remedies that may be purchased without a prescription (over the counter), through a web site, at a Physician or Chiropractor's office, or at a retail location are excluded, unless otherwise specified in the *Summary of Medical Benefits and Schedule of Medical Benefits*.

Medical Claims Administration

How Medical Benefits are Paid

Plan benefits are considered for payment on the receipt of written proof of claim, commonly called a bill. Generally, health care providers send their bill to PEBP's third-party claims administrator directly. Plan benefits for eligible services performed by health care providers will then be paid directly to the provider delivering the services. When Deductibles, Coinsurance or copayments apply, you are responsible for paying your share of these charges.

If services are provided through the PPO network, the PPO health care provider may submit the proof of claim directly to PEBP's third-party claims administrator; however, you will be responsible for the payment to the PPO health care provider for any applicable Deductible, Coinsurance, or copayments.

If a health care provider does not submit a claim directly to PEBP's third-party claims administrator and instead sends the bill to you, you should follow the steps outlined in this section regarding How to File a Claim. If, at the time you submit your claim, you furnish evidence acceptable to the Plan administrator or its designee (PEBP's third-party claims administrator) that you or your covered dependent paid some or all those charges, Plan benefits may be paid to you, but only up to the amount allowed by the Plan for those services after Plan Year Deductible and Coinsurance amounts are met.

How to File a Medical Claim

All claims must be submitted to the Plan within 12 months from the date of service. No Plan benefits will be paid for any claim submitted after this period. Benefits are based on the Plan's provisions in place on the date of service.

See also, NAC 287.610.

Most providers send their bills directly to the PEBP's claims administrator; however, for providers who do not bill the Plan directly, you may be sent a bill. In that case, follow these steps:

- Obtain a claim form from PEBP's third-party claims administrator or PEBP's website (see the *Participant Contact Guide* in this document for details on address, phone, and website).
- Complete the participant part of the claim form in full. Answer every question, even if the answer is "none" or "not applicable (N/A)."
- The instructions on the claim form will tell you what documents or medical information is necessary to support the claim. Your physician, health care practitioner or dentist can complete the health care provider part of the claim form, or you can attach the itemized bill for professional services if it contains all the following information:

- A description of the services or supplies provided including appropriate procedure codes.
- Details of the charges for those services or supplies.
- Appropriate diagnosis code.
- Date(s) the services or supplies were provided.
- Patient's name.
- Provider's name, address, phone number, and professional degree or license.
- Provider's federal tax identification number (TIN).
- Provider's signature.

Please review your bills to be sure they are appropriate and correct. Report any discrepancies in billing to the Claims Administrator. This can reduce costs to you and the Plan. Complete a separate claim form for each person for whom Plan benefits are being requested. If another plan is the primary payer, send a copy of the other plan's Explanation of Benefits (EOB) along with the claim you submit to this Plan.

To assure that medical, pharmacy or dental expenses you incur are eligible under this Plan, the Plan has the right to request additional information from any hospital, facility, physician, laboratory, radiologist, dentist, pharmacy or any other eligible medical or dental provider. For example, the Plan has the right to deny Deductible and Out-of-Pocket Maximum credit or payment to a provider if the provider's bill does not include or is missing one or more of the following components. This is not an all-inclusive list:

- Itemized bill to include but not be limited to: Proper billing codes such as CPT, HCPCS, Revenue Codes, CDT, ICD 9, and ICD 10.
- Date(s) of service.
- Place of service.
- Provider's Tax Identification Number.
- Provider's signature.
- Operative report.
- Patient ledger.
- Emergency room notes.
- Providers such as hospitals and facilities that bill for single or bulk items such as orthopedic devices/implants or other types of biomaterials shall provide to the third-party claim's administrator a copy of the manufacturer's/organization's invoice (that directly supplied the device/implant/biomaterial to the healthcare provider). This Plan will deny payment for such medical devices until a copy of the invoice is provided to this Plan's Claims Administrator.

Claims are processed by the third-party claims administrator in the order they are received.

It is your responsibility to maintain copies of the EOB documents provided to you by PEBP's third-party claims administrator or prescription drug administrator. Copies of EOB documents are available on the Claims Administrator's website but cannot be reproduced. PEBP and its third-

party claims administrator do not provide printed copies of EOB documents outside of the original mailing.

Where to Send the Claim Form

Send the completed claim form, the bill you received (retain a copy for your records) and any other required information to the Claims Administrator at the address listed in the Participant Contact Guide in this document.

Appeals

You have the right to ask PEBP or its designees to reconsider a claim or Utilization Management Adverse Benefit Determination resulting in a denial, reduction, termination, failure to provide or make payments (in whole or in part) for a service or treatment, or rescission of coverage (retroactive cancellation).

Discretionary Authority of PEBP and Designee

In carrying out their respective responsibilities under the Plan, PEBP and its designees have discretionary authority to interpret the terms of the Plan and to determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination made under that discretionary authority would be given full force and effect unless it can be shown that the interpretation or determination was arbitrary and capricious. Services that are covered, as well as specific Plan exclusions are described in this document.

Medical and Dental Claims Appeals

Written Notice of Adverse Benefit Determination

The Plan or its designee, the third-party administrator, will notify you in writing on an Explanation of Benefits (EOB) of an Adverse Claim Determination resulting in a denial, reduction, termination, or failure to provide or make payments (in whole or in part) of a benefit. The notice will explain the reasons why, with reference to the Plan provisions as to the basis for the adverse determination and it will explain what steps to take to submit a Level 1 Claim Appeal.

You will be provided with:

(a) upon request and without charge, reasonable access to and copies of all relevant documents, records, and other information relevant to your claim for benefits;

(b) the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;

(c) a full and fair review that takes into account all comments, documents, records and other information submitted by you, without regard to whether such information was submitted or considered in the initial benefit determination;

(d) automatically and free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the denied claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date.

Additionally, before the Plan issues an Adverse Benefit Determination on review based on a new or additional rationale, you will be provided, automatically and free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on

which the notice of Adverse Benefit Determination on review is required to be provided) to give you reasonable time to respond prior to that date.

If the Plan receives new or additional evidence or rationale so late in the claim filing or claim appeal process that a claimant would not have a reasonable opportunity to respond, the period for providing a final determination is delayed until such time as the claimant has had such an opportunity.

When applicable, the notice will explain what additional information is required from you and why it is needed. A participant or their designee cannot circumvent the claims and appeals procedures by initiating a cause of action against the PEBP (or the State of Nevada) in a court proceeding.

Level 1 Claim Appeal

NAC 287.670

If your claim is denied, or if you disagree with the amount paid on a claim, you may request a Level 1 Claim Appeal from the third-party administrator within 180 days of the date you received the Explanation of Benefits (EOB) which provides the claim determination. Failure to request a Level 1 Claim Appeal in a timely manner will be deemed to be a waiver of any further right of review of appeal under the Plan, unless good cause can be demonstrated. The written request for appeal must include:

- The name and Social Security Number, or identification number of the participant.
- A copy of the EOB related to the claim being appealed; and
- A detailed written explanation why the claim is being appealed.

You have the right to review documents applicable to the denial and to submit your own comments in writing. The third-party administrator will review your claim (by a person at a higher level of management than the one who originally denied the claim). If any additional information is needed to process your request for appeal, it will be requested promptly.

The third-party administrator will issue a decision of your Level 1 Claim Appeal in writing within 20 days after receipt of your request for appeal.

You will receive a notice of the appeal determination. If that determination is adverse, it will include at each level of the appeal review, the following:

(a) information that is sufficient to identify the claim involved (e.g., date of service, health care provider, claim amount if applicable);
(b) the statement that, upon request and free of charge, the diagnosis code and/or treatment code, and their corresponding meanings, will be provided. However, a request for this information will not be treated as a request for a 2nd level of appeal or external review (when external review is applicable);

(c) the specific reason(s) for the adverse appeal review decision, including the denial code and its corresponding meaning and a discussion of the decision, as well as any Plan standards used in denying the claim;
(d) reference the specific Plan provision(s) on which the determination is based;
(e) a statement that you are entitled to receive upon request, free access to and copies of documents relevant to your claim;
(f) an explanation of the Plan's appeal process and Level 2 appeal process and the external review process (when external review is applicable), along with any time limits and information regarding how to initiate the next level of review, as well as a statement of the voluntary Plan appeal procedures, if any;
(g) if the denial was based on an internal rule, guideline, protocol or similar criterion, a statement will be provided that such rule, guideline, protocol, or criteria that was relied upon will be provided free of charge to you, upon request;
(h) if the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request;
(i) the statement that "You and your Plan may have other voluntary dispute resolution options such as mediation. One way to find out what may be available is to contact your local U. S. Department of Labor Office and your State insurance regulatory agency;" and

(j) disclosure of the availability of, and contact information for, any applicable health insurance consumer assistance or ombudsman established under the Public Health Services Act to assist individuals with internal claims and appeals and external review processes (when external review is applicable).

The notification will explain the steps necessary if you wish to proceed to a Level 2 Appeal if you are not satisfied with the response at Level 1.

Level 2 Claim Appeal

NAC 287.680
If you are unsatisfied with the Level 1 Claim Appeal decision made by the third-party administrator, you may file a Level 2 Claim Appeal to the PEBP Executive Officer or designee by completing a Claim Appeal Request form. *Claim Appeal Request form*s are available at www.pebp.state.nv.us or by request by contacting PEBP Customer Service. A Level 2 Appeal must be submitted to PEBP within 35 days after you receive the Level 1 Appeal determination. Your Level 2 Appeal **must** include a copy of:

- Any document submitted with your Level 1 Appeal request.
- A copy of the Level 1 Appeal decision; and
- Any documentation to support your request.

The Executive Officer or designee will use all resources available to assure a thorough review is completed in accordance with provisions of the Plan.

A Level 2 Appeal decision will be given to you in writing by certified mail within 30 days after the Level 2 Appeal request is received by the Executive Officer or designee. A Level 2 Appeal determination will explain and reference the reasons for the decision, including the applicable provisions of the Plan upon which the determination is based.

External Claim Review

NAC 287.690

Standard Request

An External Claim Review may be requested by a participant and/or the participant's treating physician after exhausting the Level 1 and Level 2 Claim Appeals process. This means that you may have a right to have the Plan's or its designee's decision reviewed by independent health care professionals if the adverse benefit determination involved making a judgment as to the medical necessity, appropriateness, health care setting, level of care or effectiveness of the health care setting or treatment you requested.

An External Claim Review request must be submitted in writing to the Office for Consumer Health Assistance (OCHA) within four (4) months after the date of receipt of a notice of the Level 2 Claim Appeal decision. An *External Review Request Form* is available on the PEBP website at www.pebp.state.nv.us. The OCHA will assign an independent external review organization within five 5 days after receiving the request. The external review organization will issue a determination within 15 days after it receives the complete information. For standard Request for External Claim Review, a decision will be made within 45 days of receiving the request.

A Request for External Claim Review must include:

- completed and signed External Review Request Form.
- a copy of the EOB(s) related to the claim(s) being reviewed.
- a detailed written explanation why the external review is being requested; and
- any additional supporting documentation.

The Request for External Claim Review must be submitted to:

Office for Consumer Health Assistance
3320 W. Sahara Avenue, Suite 100
Las Vegas NV 89102
Phone: (702) 486-3587,
(888) 333-1597
Fax 702-486-3586
Web: *http://dhhs.nv.gov/Programs/CHA/*

Appealing a Utilization Management Determination

The utilization management (UM) company is staffed with licensed health care professionals, who utilize nationally recognized health care screening criteria along with the medical judgment of their licensed health care professional, operating under a contract with the Plan to administer

utilization review services. The review includes a process to determine the medical necessity, appropriateness, location, and cost effectiveness of health care services. Depending on the service, a review may occur before, during, or after the services are rendered, including, but not limited to precertification/pre-authorization; concurrent and/or continued stay review; discharge planning; retrospective review; and case management.

Pursuant to applicable NRS 695G, you have the following appeal processes for any adverse benefit determination made during the precertification, concurrent review, retrospective review, or case management. An appeal may be initiated by the participant, treating provider, parent, legal guardian, or person authorized to make health care decisions by a power of attorney.

The UM company will utilize a physician (other than the physician who rendered the original decision) to review the appeal. This physician is Board Certified in the area under review and is in active practice. Refer to the *Participant Contact Guide* for the UM company's contact information.

Internal UM Appeal Review

Expedited Internal UM Appeal Review

You may request an expedited appeal review of a denied precertification of a hospital admission, availability of care, continued stay or health care service for which you received emergency services but have not been discharged from the facility providing the care; or if the physician certifies that failure to proceed in an expedited manner may jeopardize your life or health or the life or health of your covered dependent or the ability for you or your covered dependent to regain maximum function.

Requests for an expedited internal UM appeal review may be made by telephone or any other reasonable means to the UM company that will ensure the timely receipt of the information required to complete the appeal process. If your physician requests a consultation with the reviewing physician, this will occur within one business day. The UM company will decide on an expedited appeal within 72 hours of receipt of the information needed to complete the appeal. The results of the determination of an expedited appeal will be provided immediately to the managing physician by phone and in writing to the patient, managing physician, facility, and the third-party claim's administrator.

If the appeal review request is denied, the UM company will provide the member with an adverse benefit determination letter including the clinical rationale for the non-certification decision and the member may pursue an external appeal as described in NRS 695G.241 - NRS 695G.275.

Standard Internal UM Appeal Review

If you have a denied precertification request (or a denial/non-certification at any other level of UM review such as concurrent review, retrospective review, or case management issue) and you do not qualify for an expedited appeal, you may request a standard appeal review. Requests for standard appeal review may be made by writing to the UM company.

Requests for standard appeal review must be made within 180 days of the date of the denial/non-certification. Actual medical records are encouraged to be provided to assist the reviewer. Standard appeals for pre-service denials will be reviewed by a physician within 15 days of the UM company's receipt of the request. Appeals for post-service treatment will be completed within 20 days of the receipt of the request. The results of the determination of a standard appeal will be provided in writing to the patient, managing physician, facility, and third-party claim's administrator.

A participant or their designee can choose to bypass the internal appeals process from adverse benefit determinations resulting from the UM company and request a review by an external review organization.

External UM Appeal Review

An external review may be requested by a participant and/or the participant's treating physician after you have exhausted the internal UM appeal review process. This means you may have the right to have the Plan Administrator or its designee's decision reviewed by independent health care professionals if the adverse benefit determination involved making a judgement as to the medical necessity, appropriateness, health care setting, level of care or effectiveness of the health care setting or treatment you requested.

Expedited Request for External Review (Pre-Service Urgent UM Appeal)

NRS 287.04335

For adverse benefit determinations resulting from the UM company, a participant or their designee can choose to bypass the internal UM appeal process and request a review by an external review organization.

Expedited external review is available only if the request is filed within four (4) months after the date of receipt of a notice of an adverse benefit determination and the patient's treating provider certifies that adherence to the time frame for the standard external review would seriously jeopardize the life or health of the covered individual or would jeopardize the covered individual's ability to regain maximum function. Pursuant to NRS 695G.271, the Office for Consumer Health Assistance (OCHA) will approve or deny a request for an external review of an adverse determination not later than 72 hours after receipt from the provider. If OCHA determines the request qualifies for expedited review, a final of the external review will made by the external review organization within 72 hours of receipt and the provider and participant will be notified within 24 hours.

A participant may file a request for an expedited external review with the Office for Consumer Health Assistance (OCHA) if the request is filed within four (4) months after the date of receipt of a notice of an adverse benefit determination or final internal adverse benefit determination. An expedited external review request form, which includes a certification of treating provider for expedited consideration can be found on the PEBP website at www.pebp.state.nv.us.

The request must be submitted to:

Office for Consumer Health Assistance
3320 W. Sahara Avenue, Suite 100
Las Vegas NV 89102
Phone: (702) 486-3587,
(888) 333-1597
Fax 702-486-3586
Web: *http://dhhs.nv.gov/Programs/CHA/*

Standard Request for External UM Review

A standard request for external UM review may be filed with the Office for Consumer Health Assistance (OCHA) if the request is filed within four (4) months after the date of receipt of a notice of an adverse benefit determination or final internal adverse benefit determination. A standard external review request form can be found on the PEBP website at www.pebp.state.nv.us.

A standard external review decision will be made within 45 days of OCHA's receipt of the request.

As with the expedited external review, a standard external review must be submitted to the Office for Consumer Health Assistance at the contact information listed above.

Experimental and/or Investigational Claim/UM External Review

If you received a denial for a service, durable medical equipment, procedure, or other therapy because the third-party administrator or the UM company determined it to be experimental and/or investigational, or subject to the No Surprises Act, or rescission of coverage, you may request an external review. To proceed with the experimental and/or investigational external review, you must obtain a certification from the treating physician indicating that the treatment would be significantly less effective if not received.

A "Physician Certification of Experimental/Investigational /Denials" is located under "Forms" on the PEBP website at www.pebp.state.nv.us.

After this form is completed by the treating physician, it should be attached to the Request for External Review" form and submitted to the Office for Consumer Health Assistance at:

Office for Consumer Health Assistance
3320 W. Sahara Avenue, Suite 100
Las Vegas NV 89102
Phone: (702) 486-3587,
(888) 333-1597
Fax 702-486-3586
Web: *http://dhhs.nv.gov/Programs/CHA/*

Prescription Drug Review and Appeals

A participant has the right to request that a medication be covered or be covered at a higher benefit (e.g., lower copay, higher quantity, etc.). The first request for coverage is called an initial

coverage review. The Pharmacy Benefit Manager reviews both clinical and administrative coverage review requests, including those cases related to specialty drugs dispensed through Accredo specialty pharmacy.

Clinical Coverage Review

The initial clinical coverage review is a request for coverage or medication that is based on clinical conditions of coverage that are set by this Plan—for example, medications that require a prior authorization. To make an initial determination for a clinical coverage review request, the prescribing physician must submit specific information for review.

How to Request a Clinical Coverage Review

The preferred method to request an initial clinical review is for the prescribing physician to submit the prior authorization request electronically. Alternately, the participant's prescribing physician or pharmacist may call Express Scripts at 1-800-753-2851 or the prescriber may submit a request in writing using a Benefit Coverage Review Form, which can be obtained by calling Express Scripts Member Services at 1-855-889-7708~~ 1-855-889-7708 or the prescriber may submit a completed Initial Coverage Review form obtained online at www.express-scripts.com/services/physicians/~~. (Home delivery coverage review requests are automatically initiated by the home delivery pharmacy as part of filling the prescription.)

Administrative Coverage Review

The initial administrative coverage review is a request for coverage of a medication that is based on the Plan's benefit design.

How to Request an Administrative Coverage Review

To request an initial administrative coverage review, the participant must submit the request in writing to Express Scripts to the attention of the Benefit Coverage Review Department (see *Participant Contact Guide* section).

For an administrative coverage review request, the participant must submit information to the pharmacy benefits manager to support the request.

If the patient's situation meets the definition of urgent under the law, an urgent review may be requested and conducted as soon as possible, but no later than 72 hours from receipt of request. In general, an urgent situation is one which, in the opinion of the attending provider, the patient's health may be in serious jeopardy or the patient may experience pain that cannot be adequately controlled while the patient waits for a decision on the review. If the patient or provider believes the patient's situation is urgent, the expedited review must be requested by calling Express Scripts at 1-800-753-2851.

If the necessary information is provided to Express Scripts so that a determination can be made, the initial determination and notification for a clinical coverage or administrative coverage review will be made within the timeframe below:

- Standard Pre-Service: 15 days for retail pharmacy and five (5) days for home delivery; and
- Standard Post-Service: 30 days.

Level 1 Appeal or Urgent Appeal

When an initial administrative or clinical coverage review request has been denied, a request for appeal of the denial may be submitted by the participant within 180 days from receipt of notice of the initial adverse benefit determination. To initiate an appeal, the following information must be submitted by mail or fax to Express Scripts' Benefit Coverage Review Department:

- Name of patient.
- Participant ID number.
- Phone number.
- The drug name for which benefit coverage has been denied.
- Brief description of why the claimant disagrees with the initial adverse benefit determination; and
- Any additional information that may be relevant to the appeal, including physician/prescriber statements/letters, bills, or any other documents.

An urgent appeal may be submitted if in the opinion of the attending provider, the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function or would subject the patient to sever pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Urgent appeals must be submitted by phone at 1-800-753-2851 or fax 1-877-852-4070 to Express Scripts. Appeals submitted by mail will not be considered urgent processing unless a subsequent phone call or fax identifies the appeal as urgent.

Express Scripts completes appeals per business policies that are aligned with state and federal regulations. Depending on the type of appeal, appeal decisions are by Express Scripts' pharmacist, physician, panel of clinicians, trained prior authorization staff member, or an independent third-party prescription drug utilization management company.

<u>Level 1 Appeal Decisions and Notifications</u>

Express Scripts will render Level 1 Appeal determinations within the following timeframes:

- Standard pre-service: 15 days.
- Standard post-service: 20 days; and
- Urgent*: 72 hours.

If new information is received and considered or relied upon in the review of the appeal, such information will be provided to the patient and prescriber together with an opportunity to

respond prior to issuance of any final adverse benefit determination. Standard Post-Service: NAC 287.670

Level 2 Appeal

When a Level 1 Appeal has been denied, a request for a Level 2 Appeal may be submitted by the participant within 35 days from receipt of notice of the Level 1 Appeal denial. To initiate a Level 2 Appeal, you must request by mail or fax to the appropriate Clinical Coverage or Administrative Coverage Review Request department.

An urgent Level 2 Appeal may be submitted if in the opinion of the attending provider, the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function or would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Urgent appeals must be submitted by phone or fax to the appropriate Clinical Coverage or Administrative Coverage Review Request department (see the *Participant Contact Guide* section). Claims and appeals submitted by mail will not be considered for urgent processing unless a subsequent phone call or fax identifies the appeal as urgent.

Level 2 Appeal Decisions and Notifications

Express Scripts will render Level 2 Appeal determinations within the following timeframes:

- Standard pre-service: 15 days.
- Standard post-service: 30 days; and
- Urgent*: 72 hours.

If new information is received and considered or relied upon in the review of the appeal, such information will be provided to the patient and prescriber together with an opportunity to respond prior to issuance of any final adverse determination. Standard Post-Service: NAC 287.680.

External Reviews

The right to request an independent external review may be available for an adverse benefit determination involving medical judgement, rescission, or a decision based on medical information, including determinations involving treatment that is considered experimental and investigation. Generally, all internal appeal rights must be exhausted prior to requesting an external review. The external review will be conducted by an independent review organization with medical experts that were not involved in the prior determination of the claim.

To submit an external review, the request must be mailed or faxed to the independent review organization (see *Participant Contact Guide*) within 4 (four) months of the date of the Level 2 Appeal denial. (If the date that is 4 (four) months from that date is a Saturday, Sunday, or a holiday, the deadline will be the next business day).

Standard External Review: the pharmacy benefit manager will review the external review request within 5 (five) business days to determine if it is eligible to be forwarded to an independent review organization (IRO) and the patient will be notified within 1 (one) business day of the decision.

If the request is eligible to be forwarded to an IRO, the request will randomly be assigned to an IRO and the Appeal information will be compiled and sent to the IRO within 5 (five) business days of assigning the IRO. The IRO will notify the claimant in writing that it has received the request for an external review and if the IRO has determined that the claim involves medical judgement or rescission, the letter will describe the claimant's right to submit additional information within 10 business days for consideration to the IRO. Any additional information the claimant submits to the IRO will also be sent back to the pharmacy benefit manager for reconsideration. The IRO will review the claim within 45 calendar days from receipt of the request and will send the claimant, the Plan and the pharmacy benefit manager written notice of its decision. If the IRO has determined that the claim does not involve medical judgement or rescission, the IRO will notify the claimant in writing that the claim is ineligible for a full external review.

Urgent External Review

Once an urgent external review request is submitted, the claim will immediately be reviewed to determine if it is eligible for an urgent external review. An urgent situation is one where in the opinion of the attending provider, the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health or the ability for the patient to regarding maximum function or would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

If the claim is eligible for urgent processing, the claim will immediately be reviewed to determine if the request is eligible to be forwarded to an IRO, and the claimant will be notified of the decision. If the request is eligible to be forwarded to an IRO, the request will randomly be assigned to an IRO and the Appeal information will be compiled and sent to the IRO. The IRO will review the claim within 72 hours from receipt of the request and will send the claimant written notice of its decision.

Coordination of Benefits

For information, refer to the separate PEBP Health and Welfare Wrap Document available at www.pebp.state.nv.us under “4.4 Coordination of Benefits” (NAC 287.755).

Subrogation and Third-Party Recovery

Subrogation applies to situations where the Participant is injured, and another person or entity is or may be responsible, liable, or contractually obligated, for whatever reason, for the payment of certain damages or claims arising from or related in any way to the Participant's injury (the "Injury"). These damages or claims arising from the Injury, irrespective of the manner in which they are categorized, may include, without limitation, medical expenses, pain and suffering, loss of consortium, and/or wrongful death. The Plan has a right of subrogation irrespective of whether the damages or claims are paid or payable to the Participant, the Participant's estate, the Participant's survivors, or the Participant's attorney(s). Any and all claims made by the Plan for which it claims a right of subrogation are referred to as Subrogated Payments.

The subrogation provision provides the Plan with a right of recovery for certain payments made by the Plan, irrespective of fault, or negligence wrongdoing. Any and all payments made by the Plan relating in any way to the Injury may be recovered directly from the other person or from any judgment, verdict or settlement obtained by the participant in relation to the injury. Refer to the separate *Health and Welfare Benefits Wrap Plan* document for more information regarding third party liability and subrogation.

The Participant must cooperate fully, at all times, and provide all information needed or requested by the Plan to recover payments, execute any papers necessary for such recovery, and do whatever is necessary or requested in order to secure and protect the Subrogation rights of the Plan. The Participant's required cooperation includes, but is not limited to, the following actions, which must be performed immediately, upon request by the Plan:

(1) Executing an acknowledgment form or other document acknowledging and agreeing to protect the Plan's right of Subrogation.
(2) Cooperating and participating in the Plan's recovery efforts, including but not limited to participating in litigation commenced or pursued by the Plan or its Board; and
(3) Filing a claim or demand with another insurance company, including but not limited to the Participant's own first party insurance policy or another person's or entity's insurance policy.

Refer to the separate Health and Welfare Benefits Wrap Plan document available at *www.pebp.state.nv.us* for more information regarding third party liability and subrogation.

Participant Contact Guide

Participant Contact Guide	
Public Employees' Benefits Program (PEBP) **901 S. Stewart Street, Suite 1001** **Carson City, NV 89701** **Customer Service:** **(775) 684-7000, (702) 486-3100 or (800) 326-5496** **Fax: (775) 684-7028** **www.pebp.state.nv.us**	**Plan Administrator** • Enrollment and eligibility • COBRA information and premium payments • Level 2 claim appeals • External review coordination
UMR **Claims Submission** **P O Box 30541** **Salt Lake City, UT 84130-0541** **EDI #39026** **Appeal of Claims** **P O Box 30546** **Salt Lake City, UT 84130-0546** **Customer Service: (888) 763-8232** **www.UMR.com** **Diabetes Care Management form submission** **UMR** **27 Corporate Hill Drive** **Little Rock, AR 77205 Fax: 800-458-0701** **Email: diabetes@HealthscopeBenefits.com**	**Third-party Claims Administrator/Third-party Administrator/PPO Network/Disease Management Administrator for Diabetes** • Claim submission • Claim status inquiries • Level 1 claim appeals • Verification of eligibility • Plan Benefit Information • CDHP & Dental only ID Cards • Obesity Care Management Program • Disease Care Management Program • Sierra Health-Care Options (SHO) – Southern Nevada PPO Network • UnitedHealthcare Choice Plus – Outside of Southern Nevada PPO Network • Behavioral Health-Care Options (BHO) – Behavioral Health Network in Nevada
Utilization Management Company **Sierra Health-Care Options, Inc** **PO BOX 15645** **Las Vegas, NV 89144-5648** **Customer Service : 888-323-1461** **Fax : 800-282-8845**	• Pre-Certification/Prior Authorization • Utilization Management • Case Management • Transplants

Express Scripts Pharmacy Benefit Administrator
Customer Service and Prior Authorization
(855) 889-7708
www.Express-Scripts.com

Accredo Patient Customer Service
(800) 803-2523

Accredo Physician Service Line
(800) 987-4904 option 5

Express Scripts / Accredo Prior Authorization
(800) 753-2851
Electronic options: express-scripts.com/PA

Specialty Medication SaveOnSP copay assistance
(800) 683-1074
www.saveonsp.com/pebp

~~**Express Scripts Pharmacy Benefit Administrator**~~

~~**Customer Service and Prior Authorization**~~

~~**(855) 889-7708**~~

~~**www.Express-Scripts.com**~~

~~**Express Scripts Home Delivery/Accredo Specialty Drug Services**~~

~~**PO Box 66566**~~

~~**St. Louis, MO 63166-6566**~~

~~**Customer Service: (855) 889-7708**~~

~~**Express Scripts Benefit Coverage Review Department**~~

~~**PO Box 66587, St. Louis, MO 63166-6587**~~

~~**Phone: 800-946-3979**~~

~~**Administrative Coverage Review and Appeals**~~

Pharmacy Benefit Manager for the CDHP
Prescription drug information

- Retail network pharmacies
- Prior authorization
- Customer service
- Formulary, forms, online ordering
- Price a Medication tool
- Home delivery service and Mail Order forms
- Preferred Mail Order for diabetic supplies

Express Scripts Clinical Appeals Department
PO Box 66588 St. Louis, MO 63166-6588
Phone: 800-753-2851
Fax: 877-852-4070

- Clinical Reviews

MCMC LLC Attn: Express Scripts Appeal Program
300 Crown Colony Dr. Suite 203
Quincy, MA 02169-0929
Phone: 617-375-7700 ext. 28253
Fax: 617-375-7683
External Review Requests

~~SaveonSP~~ ~~1-800-683-1074~~	
Diversified Dental Services **5470 Kietzke Lane, Ste 300** **Reno, NV 89511** **ProviderRelations@ddsppo.com** **1-866-270-8326** **diversifieddental.com**	PPO Dental Network • Statewide PPO Dental Providers • Dental Provider directory National PPO Dental Providers outside of Nevada utilizes the Principal Dental Network
United Healthcare **Group Number: 370074** **Customer Service: 1-888-763-8232** **UnitedHealthcare Specialty Benefits** **P.O. Box 7149** **Portland, ME 04112-7149**	• Basic Life Insurance for eligible active and retirees
The Standard Insurance Company **900 SW Fifth Avenue** **Portland, OR 97204** **(888) 288-1270** ***www.standard.com/mybenefits***	• Voluntary (Supplemental) Life Insurance • Voluntary Short-Term Disability • Travel Assistance Beneficiary designations
Office for Consumer Health Assistance **555 E. Washington Avenue, Suite 4800** **Las Vegas, NV 89101** **Customer Service:** **(702) 486-3587 or (888) 333-1597** ***http://dhhs.nv.gov/Programs/CHA/Contact_GovCHA/***	Consumer Health Assistance • Concerns and problems related to coverage • Provider billing issues External review information

Key Terms and Definitions

The following terms or phrases are used throughout this MPD. These terms or phrases have the following meanings. These terms and definitions do not, and should not be interpreted to, extend coverage under the Plan.

Accident: A sudden and unforeseen event that is not work-related, resulting from an external or extrinsic source.

Active Rehabilitation: refers to therapy in which a patient, who can learn and remember, actively participates in the rehabilitation that is intended to provide significant and measurable improvement of an individual who is restricted and cannot perform normal bodily function.

Actively Engaged:

- Participation in regular office visits with your provider. The frequency of the office visits will be determined by your provider who will in turn report this information to the third-party administrator for monitoring.
- Consistently demonstrating a commitment to weight loss by adhering to the weight loss treatment plan developed by your weight loss provider including but not limited to routine exercise, proper nutrition and diet, and pharmacotherapy if prescribed. Commitment to your weight loss treatment will be measured by the third-party administrator who will review monthly progress reports submitted by the provider; and
- Losing weight at a rate determined by the weight loss provider.

Activities of Daily Living: Activities performed as part of a person's daily routine, such as getting in and out of bed, bathing, dressing, feeding, or eating, use of the toilet, ambulating, and taking drugs or medicines that can be self-administered.

Acupuncture: A technique for treating disorders of the body by passing long thin needles through the skin. This technique is based on the belief that physical illness and disorders are caused by imbalances in the life force, called Qi, which flows through the body along meridians or channels, and that the needles stimulate the natural healing energy flow.

When benefits for the services of an acupuncturist are payable by this Plan, the acupuncturist must be properly licensed by the state in which he or she is practicing and must be performing services within the scope of that license, or, where licensing is not required, be certified by the National Certification Commission for Acupuncturists (NCCA).

Adverse Benefit Determination: NRS 695G.0–2 - Means a determination by a health carrier or utilization review organization that an admission, availability of care, continued stay or other health care service that is a covered benefit has been reviewed and, based upon the information provided, does not meet the health carrier's requirements for medical necessity,

appropriateness, health care setting, level of care or effectiveness, and the requested service or payment for the service is therefore denied, reduced or terminated.

Air Ambulance: A medical transport by a rotary wing air ambulance, as defined in 42 CFR 414.605, or fixed wing air ambulance, as defined in 42 CFR 414.605, for patients.

Allogenic: Refers to transplants of organs, tissues, or cells from one person to another person. Heart Transplants are always Allogenic.

Allowable Expenses: The Maximum Allowable Charge for any medically necessary, eligible item of expense, at least a portion of which is covered under the Plan. When some other non-Medicare plan pays first in accordance with the application to benefit determinations provision in the *Coordination of Benefits* section, this Plan's allowable expenses shall in no event exceed the other non-Medicare plan's allowable expenses.

When some other non-Medicare plan provides benefits in the form of services rather than cash payments, the Plan Administrator shall assess the value of each service rendered, by determining the amount that would be payable in accordance with the terms of the Plan, shall be deemed to be the benefit. Benefits payable under any other non-Medicare plan include the benefits that would have been payable had claim been duly made; therefore, whether or not it is made.

Ambulance: A vehicle or boat that is licensed or certified for emergency patient transportation by the jurisdiction in which it operates.

Ambulatory Surgical Facility/Center: A specialized facility that is established, equipped, operated, and staffed primarily for performing surgical procedures and which fully meets one of the following two tests:

- It is licensed as an ambulatory surgical facility/center by the regulatory authority responsible for the licensing under the laws of the jurisdiction in which it is located; or
- Where licensing is not required, it meets all the following requirements:
- It is operated under the supervision of a licensed physician who is devoting full time to supervision and permits a surgical procedure to be performed only by a duly qualified physician who, at the time the procedure is performed, is privileged to perform the procedure in at least one hospital in the area.
- It requires in all cases, except those requiring only local infiltration anesthetics, that a licensed anesthesiologist administer the anesthetic or supervise an anesthetist who is administering the anesthetic, and that the anesthesiologist or anesthetist remain present throughout the surgical procedure.
- It provides at least one operating room and at least one post-anesthesia recovery room.
- It is equipped to perform diagnostic x-ray and laboratory examinations or has an arrangement to obtain these services.
- It has trained personnel and necessary equipment to handle emergency situations.
- It has immediate access to a blood bank or blood supplies.

- It provides the full-time services of one or more registered graduate nurses (RNs) for patient care in the operating rooms and in the post-anesthesia recovery room; and
- It maintains an adequate medical record for each patient, which contains an admitting diagnosis (including, for all patients except those undergoing a procedure under local anesthesia, a preoperative examination report, medical history, and laboratory tests and/or x-rays), an operative report and a discharge summary.

An ambulatory surgical facility/center that is part of a hospital, as defined in this section, will be considered an ambulatory surgical facility/center for the purposes of this Plan.

Ancillary Services/Charges: Charges for services provided by a hospital or other facility other than room and board, including (but not limited to) use of the operating room, recovery room, intensive care unit, etc., and laboratory and x-ray services, drugs and medicines, and medical supplies provided during confinement.

Ancillary services: for purposes of the No Surprises Act, are with respect to a PPO health care facility:

- Items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a physician or non-physician practitioner,
- Items and services provided by assistant surgeons, hospitalists, and intensivists;
- Diagnostic services, including radiology and laboratory services and subject to exceptions specified by the Secretary of Department of Health and Human Services; and
- Items and services provided by a Non-PPO provider if there is no PPO provider who can furnish such item or service at such facility.

Anesthesia: The condition produced by the administration of specific agents (anesthetics) to render the patient unconscious and without conscious pain response (e.g., general anesthesia), or to achieve the loss of conscious pain response and/or sensation in a specific location or area of the body (e.g., regional, or local anesthesia). Anesthetics are commonly administered by injection or inhalation.

Annual/Annually: For the purposes of this Plan, annual and annually refers to the 12-month period starting July 1 through June 30.

Appliance (Dental): A device to provide or restore function or provide a therapeutic (healing) effect.

Appropriate: See the definition of medically necessary for the definition of appropriate as it applies to medical services that are medically necessary.

Approved Clinical Trial: A phase I, II, III, or IV trial if it is conducted for the prevention, detection, or treatment of cancer or another disease or condition likely to lead to death unless the course of the disease or condition is interrupted.

An Approved Clinical Trial's study must be (1) approved or funded by one or more of: (a) the National Institutes of Health (NIH), (b) the Centers for Disease Control and Prevention (CDC), (c) the Agency for Health Care Research and Quality (AHCRQ), (d) the Centers for Medicare and Medicaid Services (CMS), (e) a cooperative group or center of the NIH, CDC, AHCRQ, CMS, the Department of Defense (DOD), or the Department of Veterans Affairs (VA), (f) a qualified non-governmental research entity identified by NIH guidelines for grants; or (g) the VA, DOD, or Department of Energy (DOE) if the study has been reviewed and approved through a system of peer review that the Secretary of HHS determines is comparable to the system used by NIH and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review; (2) a study or trial conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA); or (3) a drug trial that is exempt from investigational new drug application requirements.

Assistant surgeon: A medically qualified doctor who assists the surgeon of record perform a procedure.

Autism Spectrum Disorders and related terms: Have the meanings ascribed to them under NRS 695G.1645 and NRS 427A.875.

Autologous: Refers to transplants of organs, tissues, or cells from one part of the body to another. Bone marrow and skin transplants are often autologous.

Average Wholesale Price (AWP): The average price at which drugs are purchased at the wholesale level.

Bariatric Surgery Center of Excellence: This provider has met the requirements outlined by the American College of Surgeons National Surgical Quality Improvement Program (ACS NSQIP) and is accredited by the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP). The accreditation of a Bariatric Surgery Center of Excellence helps identify providers with whom a participant should expect to receive safer and more effective surgical treatment. These MBSAQIP accredited providers adhere to a multidisciplinary surgical preparatory regimen to include but not limited to the following:

- Behavior modification program supervised by a qualified professional.
- Consultation with a dietician or nutritionist.
- Documentation in the medical record of the participant's active participation and compliance with the multidisciplinary surgical preparatory regimen at each visit. A physician's summary letter, without evidence of concurrent oversight is not sufficient documentation. Documentation should include medical records of the physician's initial assessment of the participant, and the physician's assessment of

the participant at the completion of the multidisciplinary surgical preparatory regimen.
- Exercise regimen (unless contraindicated) to improve pulmonary reserve prior to surgery, supervised by an exercise Therapist or other qualified professional.
- Program must have a substantial face-to-face component (must not be entirely delivered remotely); and
- Reduced-calorie diet program supervised by dietician or nutritionist.

Base Plan: The self-funded Consumer Driven Health Plan (CDHP); the base plan is also defined as the "default plan" where applicable in this document and other materials produced by PEBP (NRS 287.045).

Behavioral Health Disorder: Any illness that is defined within the mental disorders section of the current edition of the International Classification of Diseases (ICD) manual or is identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), including a psychological and/or physiological dependence on or addiction to alcohol or psychiatric drugs or medications regardless of any underlying physical or organic cause.

Behavioral health disorders covered under this Plan may include, but are not limited to depression, schizophrenia, and substance abuse and treatment that primarily uses psychotherapy or other psychotherapist methods and is provided by behavioral health practitioners as defined in this section. Certain behavioral health disorders, conditions and diseases are specifically excluded from coverage as noted in the *Exclusions* section.

Behavioral Health Practitioner: A psychiatrist, psychologist, or a mental health or substance abuse counselor or social worker who has a master's degree, or other provider who is legally licensed and/or legally authorized to practice or provide service, care, or treatment of behavioral health disorders under the laws of the state or jurisdiction where the services are rendered; and acts within the scope of his or her license.

Behavioral Health Treatment: Services, including room and board, given by a behavioral health treatment facility or area of a hospital that provides behavioral or mental health or substance abuse treatment for a mental disorder identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM). If there are multiple diagnoses, only the treatment for the illness that is identified under the DSM code is considered a behavioral health treatment for the purposes of this Plan.

Behavioral Health Treatment Facility: A specialized facility that is established, equipped, operated, and staffed primarily for providing a program for diagnosis, evaluation, and effective treatment of behavioral health disorders and which fully meets one of the following two tests:
- It is licensed as a behavioral health treatment facility by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located; or
- Where licensing is not required, it meets all the following requirements: has at least one physician on staff or on call and provides skilled nursing care by licensed nurses under the

direction of a full-time registered nurse (RN) and prepares and maintains a written plan of treatment for each patient based on the medical, psychological, and social needs of the patient.

A behavioral health treatment facility that qualifies as a hospital is covered by this Plan as a hospital and not a behavioral health treatment facility. A transitional facility, group home, halfway house or temporary shelter is not a behavioral health treatment facility under this Plan unless it meets the requirements above in the definition of behavioral health treatment facility.

Benefit, Benefit Payment, Plan Benefit: The amount of money payable for a claim, based on the usual and customary charge, subject to the Plan's Maximum Allowable Charge, or negotiated fee schedule, after calculation of all Deductibles, Coinsurance, and copayments, and after determination of the Plan's exclusions, limitations, and maximums.

Birth (or Birthing) Center: A specialized facility that is primarily a place for delivery of children following a normal uncomplicated pregnancy and which fully meets one of the two following tests:

- It is licensed by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located; or
- Where licensing is not required, it meets all the following requirements:
- It is operated and equipped in accordance with any applicable state law for providing prenatal care, delivery, immediate post-partum care, and care of a child born at the center.
- It is equipped to perform routine diagnostic and laboratory examinations, including (but not limited) to hematocrit and urinalysis for glucose, protein, bacteria and specific gravity, and diagnostic x-rays, or has an arrangement to obtain those services.
- It has available to handle foreseeable emergencies, trained personnel, and necessary equipment, including (but not limited to) oxygen, positive pressure mask, suction, intravenous equipment, equipment for maintaining infant temperature and ventilation, and blood expanders.
- It provides at least two beds or two birthing rooms.
- It is operated under the full-time supervision of a licensed physician, registered nurse (RN) or certified nurse midwife.
- It has a written agreement with at least one hospital in the area for immediate acceptance of patients who develop complications.
- It has trained personnel and necessary equipment to handle emergency situations.
- It has immediate access to a blood bank or blood supplies.
- It has the capacity to administer local anesthetic and to perform minor surgery.
- It maintains an adequate medical record for each patient that contains prenatal history, prenatal examination, any laboratory or diagnostic tests and a post-partum summary.
- It is expected to discharge or transfer patients within 48 hours following delivery.

A birth (or birthing) center that is part of a hospital, as defined in this section, will be a birth (or birthing) center for the purposes of this Plan.

Business Day: Refers to all weekdays, except Saturday, Sunday, Nevada holiday, or federal holiday.

Case Management: A process administered by the UM company in which its medical professionals work with the patient, family, caregivers, providers, Claims Administrator, Pharmacy Benefit Manager and PEBP to coordinate a timely and cost-effective treatment program. Case management services are particularly helpful when the patient needs complex, costly, and/or high-technology services, and when assistance is needed to guide patients through a maze of potential providers.

Cardiac Rehabilitation: Cardiac Rehabilitation refers to a formal program of controlled exercise training and cardiac education under the supervision of qualified medical personnel capable of treating cardiac emergencies, as provided in a hospital outpatient department or other outpatient setting. The goal is to advance the patient to a functional level of activity and exercise without cardiovascular complications to limit further cardiac damage and reduce the risk of death. Patients are to continue at home the exercise and educational techniques they learn in this program. Cardiac rehabilitation services are payable for patients who have had a heart attack (myocardial infarction) or open-heart surgery.

Certified Surgical Assistant: A person who does not hold a valid health care license as an RN, Nurse Practitioner (NP), Physician Assistant (PA), Podiatrist, Dentist, MD or DO, who assists the primary surgeon with a surgical procedure in the operating room and who bills, commonly as an assistant surgeon, and who acts within the scope of their license or certification. Such individuals are payable by this Plan, including but not limited to designation as a Certified Surgical Assistant (CSA), Certified Surgical Technologist (CST), Surgical Technologist (ST), Certified Technical Assistant (CTA), or Certified Operating Room Technician (CORT).

Chemical Dependency: This is another term for Substance Abuse. (See also the definitions of Behavioral Health Disorders and Substance Abuse).

Child(ren): See the definition of Dependent Child(ren).

Chiropractor: A person who holds the degree of Doctor of Chiropractic (DC) and is legally licensed and authorized to practice the detection and correction, by mechanical means, of the interference with nerve transmissions and expressions resulting from distortion, misalignment, or dislocation of the spinal column (vertebrae); and who acts within the scope of his or her license.

Chiropractic Services: PEBP considers chiropractic services to be medically necessary when all the following criteria are met:

- participant has objective medical findings of a neuro-musculoskeletal disorder; and
- a clearly defined treatment plan has been established including treatment and discharge goals; and

- services are not for maintenance purposes.

Christian Science Practitioner: Christian Science is a system of religious teaching based on an interpretation of scripture, founded in 1866 by Mary Baker Eddy. It emphasizes full healing of disease by mental and spiritual means. Certain members of the Christian Science church are designated as Christian Science Practitioners who counsel and assist church members in mental and spiritual means to overcome illness based on Christian Science teachings.

Chronic Medication Synchronization: "Chronic medication" means any drug that is prescribed to treat any disease or other condition which is determined to be permanent, persistent, or lasting indefinitely. "Synchronization" means the alignment of the dispensing of multiple medications by a single contracted pharmacy for improving a patient's adherence to a prescribed course of medication. This includes providing coverage for less than a 30-day supply to enable synchronization. See also NRS 695G.1665)

Claims Administrator: The person or company retained by the Plan to administer claim payment responsibilities and other administration or accounting services as specified by the Plan.

Clinical Trials: See ***Experimental and Investigational*** in the *Key Terms and Definitions* section.

Coinsurance: That portion of *Eligible Medical Expenses* for which the covered person has financial responsibility. In most instances, the covered individual is responsible for paying a percentage of covered medical expenses more than the Plan's Deductible. The Coinsurance varies depending on whether In-Network or Out-of-Network providers are used.

Complications of Pregnancy: Any condition that requires hospital confinement for medical treatment, and if the pregnancy is not terminated, is caused by an injury or sickness not directly related to the pregnancy or by acute nephritis, nephrosis, cardiac decompensation, missed abortion or similar medically diagnosed conditions; or, any condition that requires hospital confinement and if the pregnancy is terminated, results in non-elective cesarean section, ectopic pregnancy or spontaneous termination.

Compound Drugs: Any drug that has more than one ingredient and at least one of them is a Federal Legend Drug or a drug that requires a prescription under state law.

Concierge Medicine: Is a relationship between a patient and a primary care physician or dentist in which the patient usually pays an annual or monthly fee or retainer to receive easier access to a primary care provider or dentist. Concierge medicine usually means that the patient will experience quicker scheduling of appointments, limited or no waiting times, longer and more thorough examinations and coordination of all medical or dental care. Other terms in use include boutique medicine, retainer-based medicine, and innovative medical practice design. The practice is also referred to as membership medicine, concierge health care, cash only practice, direct care, direct primary care, and direct practice medicine. Most concierge medicine practices do not bill insurance.

Concurrent Review: A managed care program designed to assure that hospitalization and health care facility admissions and length of stay, surgery and other health care services are medically necessary by having the utilization management company conduct ongoing assessment of the health care as it is being provided, especially (but not limited to) inpatient confinement in a hospital or health care facility.

Continuing Care Patient: Under the NSA, an individual who, with respect to a provider or facility-

1. is undergoing a course of treatment for a serious and complex condition from the provider or facility;
2. is undergoing a course of institutional or inpatient care from the provider or facility;
3. is scheduled to undergo non-elective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such a surgery;
4. is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or
5. is or was determined to be terminally ill (as determined under section 1861(dd)(3)(A) of the Social Security Act) and is receiving treatment for such illness from such provider or facility.

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Convalescent Care Facility: See the definition of Skilled Nursing Facility.

Coordination of Benefits (COB): The rules and procedures applicable to the determination of how Plan benefits are payable when a person is covered by two or more health care plans.

Copayment, Copay: The fixed dollar amount you are responsible for paying when you incur an eligible medical expense for certain services, generally those provided by network health care practitioners, hospitals (or emergency rooms of hospitals), or health care facilities. This can be in addition to Coinsurance amounts due on the same incurred charges. Copayments are limited to certain benefits under this program.

Corrective Appliances: The general term for appliances or devices that support a weakened body part (orthotic) or replace a missing body part (prosthetic). To determine the category of any item, see also the definitions of Durable Medical Equipment, Nondurable Supplies, Orthotic Appliance (or device) and Prosthetic Appliance (or device).

Cosmetic Surgery or Treatment: Surgery or medical treatment to improve or preserve physical appearance, but not physical function. Cosmetic surgery or treatment includes medical, dental,

or surgical treatment intended to restore or improve physical appearance, as determined by the Plan Administrator, UM company, or its designee.

Cost-Efficient: See the definition of medically necessary for the definition of cost-efficient as it applies to medical services that are medically necessary.

Cost sharing: The amount a participant or beneficiary is responsible for paying for a covered item or service under the terms of the plan. Cost sharing generally includes copayments, coinsurance, and amounts paid towards deductibles, but does not include amounts paid towards premiums, balance billing by Non-PPO providers, or the cost of items or services that are not covered under the plan.

Cost Sharing Amount: for Emergency and Non-emergency Services at PPO Facilities performed by Non-PPO Providers, and air ambulance services from Non-PPO providers will be based on the Recognized Amount.

Covered Individual: Any employee or retiree (as those terms are defined in this Plan), and that person's eligible spouse or dependent child who has completed all required formalities for enrollment for coverage under the Plan and is covered by the Plan.

Covered Medical Expenses: See the definition of *Eligible Medical Expenses*.

Custodial Care: Care and services given mainly for personal hygiene or to perform the activities of daily living. Some examples of custodial care are helping patients get in and out of bed, bathe, dress, eat, use the toilet, walk (ambulate), or take drugs or medicines that can be self-administered. These services are custodial care regardless of where the care is given or who recommends, provides, or directs the care. Custodial care can be given safely and adequately (in terms of generally accepted medical standards) by people who are not trained or licensed medical or nursing personnel. Custodial care may be payable by this Plan under certain circumstances, such as when custodial care is provided during a covered hospitalization or during a covered period of hospice care.

Customary Charge: See the definition of Usual and Customary Charge.

Deductible: The amount of eligible medical, prescription drug and dental expenses you are responsible for paying before the Plan begins to pay benefits. The dental Deductibles are discussed in the separate PPO Dental Master Plan Document.

Dental: As used in this document, dental refers to any services performed by (or under the supervision of) a dentist, or supplies (including dental prosthetics). Dental services include treatment to alter, correct, fix, improve, remove, replace, reposition, restore or treat teeth; the gums and tissues around the teeth; the parts of the upper or lower jaws that contain the teeth (the alveolar processes and ridges); the jaw, any jaw implant, or the joint of the jaw (the Temporomandibular Joint); bite alignment, or the meeting of upper or lower teeth, or the

chewing muscles; and/or teeth, gums, jaw or chewing muscles because of pain, injury, decay, malformation, disease or infection. Dental services and supplies coverage is provided in the PPO Dental Plan (refer to the separate PPO Dental Plan MPD available at www.pebp.state.nv.us) and are not covered under the medical expense coverage of this Plan unless the medical Plan specifically indicates otherwise in the *Schedule of Medical Benefits*.

Dependent: Any of the following individuals: Dependent child(ren), spouse or domestic partner as those terms are defined in this document.

Dependent Child(ren): See also (NAC 287.312)
For the purposes of this Plan, a dependent child is any of your children under the age of 26 years, including:

- natural child,
- child(ren) of a domestic partner,
- stepchild,
- legally adopted child or child placed in anticipation for adoption (the term placed for adoption means the assumption and retention by the employee of a legal obligation for total or partial support of the child in anticipation of adoption of the child and the child must be available for adoption and the legal adoption process must have commenced),
- child who qualifies for benefits under a QMCSO/NMSN (see the *Eligibility* section for details on QMCSO/NMSN),
- any other person who:
  (1) Bears a relationship described in 26 U.S.C. § 152(c)(2) to the participant or his or her spouse or domestic partner.
  (2) Is unmarried.
  (3) Has not attained the age set forth in 45 C.F.R. § 147.120(a).
  (4) Either resides with the participant or is enrolled in a program of secondary education or an independently accredited program of postsecondary education, including, without limitation, a college, university, community or junior college, graduate school or accredited trade or business school, on a full-time basis
  (5) Satisfies one of the following conditions:
    a. Is currently under a permanent legal guardianship of the participant or his or her spouse or domestic partner pursuant to chapter 159 of NRS; or
    b. Was eligible to be claimed as a dependent on the federal income tax return of the participant or his or her spouse or domestic partner for the immediately preceding calendar year; and
  (6) Is in a relationship with the participant or his or her spouse or domestic partner that is like a child-parent relationship. The participant or his or her spouse or domestic partner must complete and submit to the Program an affidavit attesting to the fact of the relationship.

Disability: A determination by the Plan Administrator or its designee (after evaluation by a physician) that a person has a permanent or continuing physical or mental impairment causing the person to be unable to be self-sufficient as the result of having the physical or mental impairment such as intellectual disability, cerebral palsy, epilepsy, neurological disorder, or psychosis.

Domestic Partner: As defined by NRS 122A.030.

Drug: See the definition for prescription drug.

Durable Medical Equipment: Equipment that can withstand repeated use; and is primarily and customarily used for a medical purpose and is not generally useful in the absence of an injury or illness; and is not disposable or non-durable and is appropriate for the patient's home. Durable medical equipment includes (but is not limited to) apnea monitors, blood sugar monitors, commodes, electric hospital beds with safety rails, electric and manual wheelchairs, nebulizers, oximeters, oxygen and supplies, and ventilators.

Elective Hospital Admission, Service or Procedure: Any non-emergency hospital admission, service or procedure that can be scheduled or performed at the patient's or physician's convenience without jeopardizing the patient's life or causing serious impairment of body function.

Eligible Medical Expenses: Expenses for medical services or supplies, but only to the extent that they are medically necessary; and the charges for them are usual and customary and do not exceed the Plan's Maximum Allowable Charge or negotiated fee schedule; and coverage for the services or supplies is not excluded (as provided in the *Exclusions* section); and the Plan Year maximum benefits for those services or supplies has not been reached.

Emergency: See the definition for Medical Emergency.

Emergency Medical Condition: A medical condition, including mental health condition or substance use disorder, manifested by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in serious impairment to bodily functions, serious dysfunction of any bodily organ or part, or placing the health of a woman or her unborn child in serious jeopardy.

Emergency Care: Medical and health services provided for an Emergency Medical Condition as defined above.

This Plan does not require precertification for medically necessary emergency services provided at any hospital in accordance with NRS 695G.170. For information, refer to the separate PEBP Health and Welfare Wrap Document available at www.pebp.state.nv.us.

Emergency Services means the following:

1. An appropriate medical screening examination that is within the capability of the emergency department of a hospital or of an independent freestanding emergency department, as applicable, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and
2. Within the capabilities of the staff and facilities available at the hospital or the independent freestanding emergency department, as applicable, such further medical examination and treatment as are required to stabilize the patient (regardless of the department of the hospital in which such further examination or treatment is furnished).

Emergency Services furnished by a Non-PPO provider or Non-PPO emergency facility (regardless of the department of the hospital in which such items or services are furnished) also include post stabilization services (services after the patient is stabilized) and as part of outpatient observation or an inpatient or outpatient stay related to the emergency medical condition, until:

- The provider or facility determines that the participant or beneficiary is able to travel using nonmedical transportation or nonemergency medical transportation; or
- The participant or beneficiary is supplied with a written notice, as required by federal law, that the provider is a Non-PPO provider with respect to the Plan, of the estimated charges for your treatment and any advance limitations that the Plan may put on your treatment, of the names of any PPO providers at the facility who are able to treat you, and that you may elect to be referred to one of the PPO providers listed; and
- The participant or beneficiary gives informed consent to continued treatment by the Non-PPO provider, acknowledging that the participant or beneficiary understands that continued treatment by the Non-PPO provider may result in greater cost to the participant or beneficiary.

See also NRS 695G.170.

Emergency Surgery: A surgical procedure performed within 24 hours of the sudden and unexpected severe symptom of an illness, or within 24 hours of an accidental injury causing a life-threatening situation.

Employee: Unless specifically indicated otherwise when used in this document, employee refers to a person employed by an agency or entity that participates in the PEBP program, and who is eligible to enroll for coverage under this Plan.

Employer: Unless specifically indicated otherwise when used in this document, employer refers to an agency or entity that participates in the PEBP program, including (but not limited to) most State agencies, as well as some county and city agencies and organizations.

Enteral Formulas: Enteral Formulas is subject to NRS 689B.0353.

Exclusions: Specific conditions, circumstances, and limitations, as set forth in the *Exclusions* section for which the Plan does not provide Plan benefits.

Experimental and/or Investigational Services: See also NRS 695G.173: Required provision concerning coverage for treatment received as part of clinical trial or study.

Unless mandated by law, the Plan Administrator, UM company, or its designee has the discretion and authority to determine if a service or supply is, or should be, classified as experimental and/or investigational. A service or supply will be deemed to be experimental and/or investigational if, in the opinion of the Plan Administrator, UM company, or its designee, based on the information and resources available at the time the service was performed or the supply was provided, or the service or supply was considered for precertification under the Plan's utilization management program, any of the following conditions were present with respect to one or more essential provisions of the service or supply:

- The service or supply is described as an alternative to more conventional therapies in the protocols (the plan for the course of medical treatment that is under investigation) or consent document (the consent form signed by or on behalf of the patient) of the health care provider that performs the service or prescribes the supply.
- The prescribed service or supply may be given only with the approval of an Institutional Review Board as defined by federal law.
- In the opinion of the Plan Administrator or its designee, there is either an absence of authoritative medical, dental or scientific literature on the subject, or a preponderance of such literature published in the United States, and written by experts in the field, that shows that recognized medical, dental or scientific experts: classify the service or supply as experimental and/or investigational; or indicate that more research is required before the service or supply could be classified as equally or more effective than conventional therapies.
- With respect to services or supplies regulated by the Food and Drug Administration (FDA), FDA approval is required for the service and supply to be lawfully marketed; and it has not been granted at the time the service or supply is prescribed or provided; or a current Investigational new drug or new device application has been submitted and filed with the FDA. However, a drug will not be considered experimental and/or investigational if it is:
    - Approved by the FDA as an "Investigational new drug for treatment use"; or
    - Classified by the National Cancer Institute as a Group C cancer drug when used for treatment of a "life threatening disease," as that term is defined in FDA regulations; or
    - Approved by the FDA for the treatment of cancer and has been prescribed for the treatment of a type of cancer for which the drug was not approved for general use, and the FDA has not determined that such drug should not be prescribed for a given type of cancer.

- The prescribed service or supply is available to the covered person only through participation in Phase I or Phase II clinical trials; **or** Phase III Experimental or research clinical trials or corresponding trials sponsored by the FDA, the National Cancer Institute, or the National Institutes of Health.

In determining if a service or supply is or should be classified as experimental and/or Investigational, the Plan Administrator or its designee will rely only on the following specific information and resources that are available at the time the service or supply was performed, provided, or considered for precertification under the Plan's utilization management program:

- Medical records of the covered person.
- The consent document signed, or required to be signed, to receive the prescribed service or supply.
- Protocols of the health care provider that renders the prescribed service or prescribes or dispenses the supply.
- Authoritative peer-reviewed medical or scientific writings that are published in the United States regarding the prescribed service or supply for the treatment of the covered person's diagnosis, including (but not limited to) "United States Pharmacopoeia Dispensing Information"; and "American Hospital Formulary Service".
- The published opinions of the American Medical Association (AMA), such as "The AMA Drug Evaluations" and "The Diagnostic and Therapeutic Technology Assessment (DATTA) Program, etc.; or specialty organizations recognized by the AMA; or the National Institutes of Health (NIH); or the Center for Disease Control (CDC); or the Office of Technology Assessment; or the American Dental Association (ADA), with respect to dental services or supplies.
- Federal laws or final regulations that are issued by or applied to the FDA or Department of Health and Human Services regarding the prescribed service or supply.
- The latest edition of "The Medicare Coverage Issues Manual."

To determine how to obtain a precertification of any procedure that might be deemed to be experimental and/or investigational, see the *precertification* in the *Utilization Management* section.

Explanation of Benefits (EOB): When a claim is processed by the claims administrator you will be sent a form called an Explanation of Benefits, or EOB. The EOB describes how the claim was processed, such as allowed amounts, amounts applied to your Deductible, if your out-of-pocket maximum has been reached, if certain services were denied and why, amounts you need to pay to the provider, etc.

Extended Care Facility: See the definition of Skilled Nursing Facility.

Expedited Appeal: If a participant appeals a decision regarding a denied request for precertification (pre-service claim) for an urgent care claim, the participant or participant's authorized representative can request an expedited appeal, either orally or in writing. Decisions

regarding an expedited appeal are generally made within seventy-two (72) hours from the Plan's receipt of the request.

External Review: An independent review of an adverse benefit determination conducted by an external review organization.

External Review Organization: An organization that 1) conducts an external review of a final adverse benefit determination; and 2) is certified in accordance with regulations adopted by the Nevada Commissioner of Insurance.

Federal Legend Drugs: Any medicinal substance that the Federal Food, Drug and Cosmetic Act requires to be labeled, "Caution — Federal Law prohibits dispensing without prescription."

Food and Drug Administration (FDA): The U.S. government agency responsible for administration of the Food, Drug and Cosmetic Act and whose approval is required for certain prescription drugs and other medical services and supplies to be lawfully marketed.

Free-Standing Laboratory Facility: Free-standing laboratory facilities are stand-along facilities that are not affiliated with a hospital system. Examples of preferred free-standing laboratory facilities include Labor Corp or Quest.

Formulary: A list of generic and brand name drug products available for use by participants. This is maintained by the Pharmacy Benefit Manager and may be subject to change according to the Pharmacy Benefit Manager.

Gender Dysphoria: Gender Dysphoria, as defined by the American Psychiatric Association, refers to psychological distress that results from an incongruence between one's sex assigned at birth and one's gender identity. Generally, it is a condition in which the person has the desire to live as a member of the opposite sex and progressively take steps to live in the opposite sex role full-time.

Generic; Generic Drug: A prescription drug that has the equivalency of the brand name drug with the same use and metabolic disintegration. This Plan will consider as a generic drug any FDA approved generic pharmaceutical dispensed according to the professional standards of a licensed Pharmacist and clearly designated by the pharmacist as being generic. (See also the Prescription Drug section of the *Schedule of Medical Benefits* and the *Prescription Drug* subsection of the *Medical Exclusion* section).

Genetic Counseling: Counseling services provided before or in the absence of genetic testing to educate the patient about issues related to chromosomal abnormalities or genetically transmitted characteristics and/or the possible impacts of the results of genetic testing; and provided after Genetic Testing to explain to the patient and his or her family the significance of any detected chromosomal abnormalities or genetically transmitted characteristics that indicate

either the presence of or predisposition to a disease or disorder of the individual tested, or the presence of or predisposition to a disease or disorder in a fetus of a pregnant woman.

Genetic Information: Information regarding the presence or absence of chromosomal abnormalities or genetically transmitted characteristics in a person that is obtained from genetic testing, or that may be inferred from a person's family medical history.

Genetic Testing: Tests that involve the extraction of DNA from an individual's cells and analysis of that DNA to detect the presence or absence of chromosomal abnormalities or genetically transmitted characteristics that indicate the presence of a disease or disorder, the individual's predisposition to a disease or disorder, or the probability that the chromosomal abnormality or characteristic will be transmitted to that person's child, who will then either have that disease or disorder, a predisposition to develop that disease or disorder, or become a carrier of that abnormality or characteristic with the ability to transmit it to future generations. Tests that assist the health care practitioner in determining the appropriate course of action or treatment for a medical condition.

Gestational carrier: Gestational carrier means an adult woman who is not an intended parent and who enters into a gestational agreement to bear a child conceived using the gametes of other persons and not her own. NRS 126.580.

Government-Provided Services: Expenses for health care services provided to a covered participant that federal, state, or local law (e.g., Tricare/Champus, VA, except the Medicaid program), expenses for care required by a public entity and care for which there would not normally be a charge.

Health Care Facility: (for non-emergency services) is each of the following:

1. A hospital (as defined in section 1861(e) of the Social Security Act);
2. A hospital outpatient department;
3. A critical access hospital (as defined in section 1861(mm)(1) of the Social Security Act); and
4. An ambulatory surgical center described in section 1833(i)(1)(A) of the Social Security Act

Health Care Practitioner: A physician, behavioral health practitioner, chiropractor, dentist, nurse, nurse practitioner, physician assistant, podiatrist, or occupational, physical, respiratory or speech therapist or speech pathologist, master's prepared audiologist, optometrist, optician for vision Plan benefits, oriental medicine doctor for acupuncture or Christian Science Practitioner, or other provider who is legally licensed and/or legally authorized to practice or provide certain health care services under the laws of the state or jurisdiction where the services are rendered: and acts within the scope of his or her license and/or scope of practice.

Health Care Provider: A health care practitioner as defined above, or a hospital, ambulatory surgical facility, behavioral health treatment facility, birthing center, home health care agency,

hospice, skilled nursing facility, or sub-acute care facility (as those terms are defined in this *Key Terms and Definitions* section).

HIPAA: Health Insurance Portability and Accountability Act of 1996. Federal regulation affecting portability of coverage; electronic transmission of claims and other health information; privacy and confidentiality protections of health information.

HIPAA Special Enrollment: Enrollment rights under HIPAA for certain employees and dependents who experience a loss of other coverage and when there is an adoption, placement for adoption, birth, or marriage.

Home Health Care: Intermittent skilled nursing care services provided by a licensed home health care agency (as those terms are defined in this section).

Home Health Care Agency: An agency or organization that provides a program of Home Health Care and meets one of the following three tests:

- It is approved by Medicare; or
- It is licensed as a home health care agency by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located; or
- If licensing is not required, it meets all the following requirements:
- It has the primary purpose of providing a home health care delivery system bringing supportive skilled nursing and other therapeutic services under the supervision of a physician or registered nurse to the home.
- It has a full-time administrator.
- It is run according to rules established by a group of professional health care providers including physicians and registered nurses.
- It maintains written clinical records of services provided to all patients.
- Its staff includes at least one registered nurse, or it has nursing care by a registered nurse available.
- Its employees are bonded.
- It maintains malpractice insurance coverage.

Homeopathy: A school of medicine based on the theory that when large doses of drugs or substances produce symptoms of an illness in healthy people, administration of very small doses of those drugs or substances will cure the same symptoms. Homeopathy principles are designed to enhance the body's natural protective mechanisms based on a theory that "like cures like" or "treatment by similar." See also the *Exclusions* section of this document regarding homeopathic treatment and services. When the services of homeopaths are payable by this Plan (e.g., an office visit), the homeopath must be properly licensed to practice homeopathy in the state in which he or she is practicing and must be performing services within the scope of that license or, where licensing is not required, have successfully graduated with a diploma of Doctor of Medicine in Homeopathy from an institution which is approved by the American Institute of Homeopathy and completed at least 90 hours of formal post- graduate courses or training in a program approved by the American Institute of Homeopathy.

Hospice: An agency or organization that administers a program of palliative and supportive health care services providing physical, psychological, social, and spiritual care for terminally ill persons assessed to have a limited life expectancy. Hospice care is intended to let the terminally ill spend their last days with their families at home (home hospice services) or in a home-like setting (inpatient hospice), with emphasis on keeping the patient as comfortable and free from pain as possible and providing emotional support to the patient and his or her family.

A hospice agency must meet one of the following tests:

- It is approved by Medicare; or is licensed as a hospice agency by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located; or
- If licensing is not required, it meets all the following requirements:
    a. It provides 24 hour-a-day, 7 day-a-week service.
    b. It is under the direct supervision of a duly qualified physician.
    c. It has a full-time administrator.
    d. It has a nurse coordinator who is a registered nurse with four years of full-time clinical experience. Two of these years must involve caring for terminally ill patients.
    e. The main purpose of the agency is to provide hospice services.
    f. It maintains written records of services provided to the patient.
    g. It maintains malpractice insurance coverage.
    h. A hospice agency that is part of a hospital will be considered a hospice agency for the purposes of this Plan.

Hospital: A public or private facility or institution, other than one owned by the U.S Government, licensed and operating according to law, that:

- Is legally operated in the jurisdiction where it is located.
- Is engaged mainly in providing inpatient medical care and treatment for injury and illness in return for compensation.
- Has organized facilities for diagnosis and major surgery on its premises.
- Is supervised by a staff of at least two physicians.
- Has 24-hour-a-day nursing service by registered nurses; and
- Is not a facility specializing in dentistry; or an institution which is mainly a rest home; a home for the aged; a place for drug addicts; a place for alcoholics; a convalescent home; a nursing home; an extended care or skilled nursing facility or similar institution; or a Long-Term Acute Care Facility (LTAC).

A hospital may include facilities for behavioral health treatment that are licensed and operated according to law. Any portion of a hospital used as an ambulatory surgical facility, birth (or birthing) center, hospice, skilled nursing facility, sub-acute care facility, or other place for rest, custodial care, or the aged shall not be regarded as a hospital for any purpose related to this Plan.

Illness: Any bodily sickness or disease, including any congenital abnormality of a newborn child, as diagnosed by a physician, and as compared to the person's previous condition. Pregnancy of a covered employee or covered spouse will be an illness only for coverage under this Plan. However, infertility is not an illness for coverage under this Plan.

Independent Freestanding Emergency Department: A health-care facility (not limited to those described in the definition of health care facility) that is geographically separate and distinct from a hospital under applicable State law and provides Emergency Services.

Inherited Metabolic Disorder: A genetically acquired disorder of metabolism involving the inability to properly metabolize amino acids, carbohydrates, or fats, as diagnosed by a physician using standard blood, urine, spinal fluid, tissue, or enzyme analysis. Inherited Metabolic Disorders are also referred to as inborn errors of metabolism and include Phenylketonuria (PKU), Maple Syrup Urine Disease, Homocystinuria and Galactosemia. Lactose intolerance without a diagnosis of Galactosemia is not an Inherited Metabolic Disorder under this Plan. See Special Food Products.

Injury: Any damage to a body part resulting from trauma from an external source.

Injury to Teeth: An injury to the teeth caused by trauma from an external source. This does not include an injury to the teeth caused by any intrinsic force, such as the force of biting or chewing. Benefits for injury to teeth are payable under the medical Plan.

In-Network Provider: Means an In-Network provider that the network or one of its rental networks have contracted with or have arrangements with to provide health services to covered individuals. An In-Network provider has agreed to charge participants a discounted rate. To determine if a provider is an In-Network provider log on to www.pebp.state.nv.us. You may also call the number of the back of your ID card and a customer service representative can help you locate an In-Network provider.

In-Network Services: Services provided by a health care provider that is a member of the Plan's Preferred Provider Organization (PPO), as distinguished from Out-of-Network services that are provided by a health care provider that is not a member of the PPO network.

In-Network Contracted Rate: The negotiated amount determined by the PPO network to be the maximum amount charged by the PPO provider for a covered service. In some cases, the In-Network contracted amount may be applied to Out-of-Network provider charges.

Inpatient Services: Services provided in a hospital or other health care facility during the period when charges are made for room and board.

Intensive Care Unit: A section, ward, or wing within the hospital which:

- Is separated from other hospital facilities.

- Is operated exclusively for providing professional care and treatment for critically ill patients.
- Has special supplies and equipment necessary for such care and treatment available on a standby basis for immediate use.
- Provides room and board; and
- Provides constant observation and care by registered nurses or other specially trained hospital personnel.

Intensive Outpatient Program: An intensive outpatient program (IOP) is a kind of treatment service and support program used primarily to treat eating disorders, depression, self-harm, and chemical dependency that does not rely on detoxification. IOP operates on a small scale and does not require the intensive residential or partial day services typically offered by the larger, more comprehensive treatment facilities.

Maintenance Care: Services and supplies provided primarily to maintain, support and/or preserve a level of physical or mental function rather than to improve such function.

Maintenance Rehabilitation refers to therapy in which a patient actively participates, that is provided after a patient has met the functional goals of active rehabilitation so that no continued significant and measurable improvement is reasonably and medically anticipated, but where additional therapy of a less intense nature and decreased frequency may reasonably be prescribed to maintain, support, and or preserve the patient's functional level. Maintenance rehabilitation is not covered by the Plan.

Managed Care: Procedures designed to help control health care costs by avoiding unnecessary services or services that are costlier than others that can achieve the same result.

Maximum Amount; Maximum Allowable Charge: The benefit payable for a specific coverage item or benefit under the Plan. Maximum allowable charge(s) shall be calculated by the Plan Administrator considering and after having analyzed:

- The reasonable and appropriate amount.
- The terms of the Plan.
- Plan negotiated and contractual rates with provider(s).
- The actual billed charges for the covered services; and
- Unusual circumstances or complications requiring additional time, skill, and experience in connection with a service or supply, industry standards and practices as they relate to similar scenarios, and the cause of injury or illness necessitating the service(s) and/or charge(s).
- Medicare Allowable.

The Plan will reimburse the actual charge(s) if they are less than the Plan's Maximum Allowable Charge amount(s). The Plan has the discretionary authority to decide if a charge is reasonable and appropriate, as well as medically necessary. The Maximum Allowable Charge will not include

any identifiable billing mistakes including, but not limited to, up-coding, duplicate charges, and charges for services not performed.

Medically Necessary: A medical or dental service or supply will be determined to be "medically necessary" by the Plan Administrator or its designee if it:

- Is provided by or under the direction of a physician or other duly licensed health care practitioner who is authorized to provide or prescribe it (or dentist if a dental service or supply is involved); and
- Is determined by the Plan Administrator or its designee to be necessary in terms of generally accepted American Medical and Dental standards; and
- Is determined by the Plan Administrator or its designee to meet all the following requirements:
- It is consistent with the symptoms or diagnosis and treatment of the illness or injury; and
- It is not provided solely for the convenience of the patient, physician, dentist, hospital, health care provider, or health care facility; and
- It is an appropriate service or supply given the patient's circumstances and condition; and
- It is a cost-efficient supply or level of service that can be safely provided to the patient; and
- It is safe and effective for the illness or injury for which it is used.

A medical or dental service or supply will be appropriate if:

- It is a diagnostic procedure that is called for by the health status of the patient and is: as likely to result in information that could affect the course of treatment as; and no more likely to produce a negative outcome than any alternative service or supply, both with respect to the illness or injury involved and the patient's overall health condition.
- It is care or treatment that is likely to produce a significant positive outcome; and no more likely to produce a negative outcome than any alternative service or supply, both with respect to the illness or injury involved and the patient's overall health condition.
- A medical or dental service or supply will be cost-efficient if it is no costlier than any alternative appropriate service or supply when considered in relation to all health care expenses incurred in connection with the service or supply. The fact that your physician or dentist may provide, order, recommend or approve a service or supply does not mean that the service or supply will be medically necessary for the medical or dental coverage provided by the Plan. A hospitalization or confinement to a health care facility will not be medically necessary if the patient's illness or injury could safely and appropriately be diagnosed or treated while not confined. A medical or dental service or supply that can safely and appropriately be furnished in a physician's or dentist's office or other less costly facility will not be medically necessary if it is furnished in a hospital or health care facility or other costlier facility:
- The non-availability of a bed in another health care facility, or the non-availability of a Health Care Practitioner to provide medical services will not result in a determination that continued confinement in a hospital or other health care facility is medically necessary.

- A medical or dental service or supply will not be considered medically necessary if it does not require the technical skills of a dental or health care practitioner or if it is furnished mainly for the personal comfort or convenience of the patient, the patient's family, any person who cares for the patient, any dental or health care practitioner, hospital, or health care facility.

Medically Necessary for External Review: Means health care services or products that a prudent physician would provide to a patient to prevent, diagnose or treat an illness, injury or disease or any symptoms thereof that are necessary and provided in accordance with generally accepted standards of medical practice, is clinically appropriate with regard to type, frequency, extent, location and duration, is not primarily provided for the convenience of the patient, physician or other provider of healthcare, is required to improve a specific health condition of a member or to preserve his existing state of health and the most clinically appropriate level of healthcare that may be safely provided to the participant.

Medicare: The Health Insurance for the Aged and Disabled provisions in Title XVIII of the U.S. Social Security Act as it is now amended and as it may be amended in the future.

Medicare Part A: Hospital insurance provided by the federal government that helps cover inpatient care in hospitals, skilled nursing facility, hospice, and home health care.

Medicare Part B: Medical insurance provided by the federal government that helps pay for medically necessary services like doctors' services, outpatient care, durable medical equipment, home health services, and other medical services.

Medicare Part D: Prescription drug coverage subsidized by the federal government but is offered only by private companies contracted with Medicare such as HMOs and PPOs.

Medi-Span: A national drug pricing information database for drug pricing analysis and comparison.

Mental Disorder; Mental and Nervous Disorder: See the definition of Behavioral Health Disorder.

Midwife, Nurse Midwife: A person legally licensed as a Midwife or certified as a Certified Nurse Midwife in the area of managing the care of mothers and babies throughout the maternity cycle, as well as providing general gynecological care, including history taking, performing physical examinations, ordering laboratory tests and x-ray procedures, managing labor, delivery and the post-delivery period, administer intravenous fluids and certain medications, provide emergency measures while awaiting aid, perform newborn evaluation, sign birth certificates, and bill and be paid in his or her own name, and who acts within the scope of his or her license. A Midwife may not independently manage moderate or high-risk mothers, admit to a hospital, or prescribe all types of medications. See also the definition of Nurse.

Morbid Obesity: Characterized by body mass index >40 kg/m(2) as defined by the National Library of Medicine. **Naturopathy:** A therapeutic system based on principles of treating diseases with natural forces such as water, heat, diet, sunshine, stress reduction, physical manipulation, massage, or herbal tea. Note: Naturopathy providers, treatment, services, or substances are not a payable benefit under this Plan.

No Surprises Act means the federal No Surprises Act (Public Law 116-260, Division BB).

Nondurable Supplies: Goods or supplies that cannot withstand repeated use and/or that are considered disposable and limited to either use by a single person or one-time use, including (but not limited to) bandages, hypodermic syringes, diapers, soap, or cleansing solutions, etc. See also the definitions of Corrective Appliances, Durable Medical Equipment, Orthotic Appliance (or Device) and Prosthetic Appliance (or Device). Only those Nondurable Supplies identified in the *Schedule of Medical Benefits* are covered by this Plan. All others are not.

Non-Network: See Out-of-Network.

Non-PPO emergency facility: An emergency department of a hospital, or an independent freestanding emergency department (or a hospital, with respect to Emergency Services as defined), that does not have a contractual relationship directly or indirectly with a group health plan or group health insurance coverage offered by a health insurance issuer, with respect to the furnishing of an item or service under the plan or coverage respectively

Non-PPO Provider or Non-Participating Provider: A health care provider who does not have a contractual relationship directly or indirectly with the Plan with respect to the furnishing of an item or service under the Plan.

Nurse: A person legally licensed as a Registered Nurse (RN), Certified Registered Nurse Anesthetist (CRNA), Certified Nurse Midwife or licensed Midwife, Nurse Practitioner (NP), Licensed Practical Nurse (LPN), Licensed Vocational Nurse (LVN), Psychiatric Mental Health Nurse, or any equivalent designation, under the laws of the state or jurisdiction where the services are rendered, who acts within the scope of his or her license.

Nurse Anesthetist: A person legally licensed as a Certified Registered Nurse Anesthetist (CRNA), Registered Nurse Anesthetist (RNA) or Nurse Anesthetist (NA) and authorized to administer Anesthesia in collaboration with a physician, and bill and be paid in his or her own name, or any equivalent designation, under the laws of the state or jurisdiction where the services are rendered, who acts within the scope of his or her license.

Nurse Practitioner: A person legally licensed as a Nurse Practitioner (NP), or Registered Nurse Practitioner (RNP) who acts within the scope of his or her license and who in collaboration with a physician, examines patients, establishes medical diagnoses; orders, performs and interprets

laboratory, radiographic and other diagnostic tests, identifies, develops, implements and evaluates a plan of patient care, prescribes and dispenses medication, refers to and consults with appropriate health care practitioners under the laws of the state or jurisdiction where the services are rendered.

Obesity: Body mass index of 30 kg/m2 or higher is used to identify individuals with obesity as defined by the National Library of Medicine.

Occupational Therapist: A person legally licensed as a professional occupational therapist who acts within the scope of their license and acts under the direction of a physician to assess the presence of defects in an individual's ability to perform self-care skills and activities of daily living and who formulates and carries out a plan of action to restore or support the individual's ability to perform such skills to regain independence.

Office Visit: A direct personal contact between a physician or other health care practitioner and a patient in the health care practitioner's office for diagnosis or treatment associated with the use of the appropriate office visit code in the Current Procedural Terminology (CPT) manual of the American Medical Association and with documentation that meets the requirement of such CPT coding. Neither a telephone discussion with a physician or other health care practitioner nor a visit to a health care practitioner's office solely for such services as blood drawing, leaving a specimen, or receiving a routine injection is an office visit for the purposes of this Plan.

Open Enrollment Period: The period during which participants in the Plan may select among the alternate health benefit programs that are offered by the Plan or eligible individuals not currently enrolled in the Plan may enroll for coverage.

Oral Surgery: The specialty of dentistry concerned with surgical procedures in and about the mouth and jaw.

Orthognathic Services: Services dealing with the cause and treatment of malposition of the bones of the jaw, such as Prognathism, Retrognathism or TMJ syndrome. See the definitions of Prognathism, Retrognathism and TMJ.

Orthotic (Appliance or Device): A type of corrective appliance or device, either customized or available "over-the-counter," designed to support a weakened body part, including (but not limited to) crutches, custom designed corsets, leg braces, extremity splints, and walkers. For the purposes of the medical Plan, this definition does not include dental orthotics. See also the definitions of Corrective Appliance, Durable Medical Equipment, Nondurable Supplies and Prosthetic Appliance (or Device).

Other Prescription Drugs: Drugs that require a prescription under state law but not under federal law.

Out-of-Network Rate: With respect to items and services furnished by a Non-PPO provider, Non-Network emergency facility or Non-PPO provider of ambulance services, means one of the following:

- the amount the parties negotiate;
- the amount approved under the independent dispute resolution (IDR) process; or
- if the state has an All-Payer Model Agreement, the amount that the state approves under that system

Out-of-Network Services (Non-Network): Services provided by a health care provider that is not a member of the Plan's Preferred Provider Organization (PPO), as distinguished from In-Network services that are provided by a health care provider that is a member of the PPO. Greater expense could be incurred by the participant when using Out-of-Network providers.

Out-of-Pocket Maximum: The maximum amount of Coinsurance each covered person or family is responsible for paying during a Plan Year before the Coinsurance required by the Plan ceases to apply. When the Out-of-Pocket Maximum is reached, the Plan will pay 100% of eligible covered expenses for the remainder of the Plan Year. See the section on Out-of-Pocket Maximum in the *Medical Expense Coverage* section for details about what expenses do not count toward the Out-of-Pocket Maximum.

Outpatient Hospital Laboratory and Outpatient Hospital-Based Laboratory Draw Station: Outpatient hospital-based laboratory facilities include lab services performed in a hospital outpatient setting. Outpatient hospital-based laboratory draw stations are hospital affiliated whereby the draw station collects specimens and sends them to the central hospital lab for processing.

Outpatient Services: Services provided either outside of a hospital or health care facility setting or at a hospital or health care facility when room and board charges are not incurred.

Partial Hospitalization Service: Also known as PHP, is a type of program used to treat mental illness and substance abuse in which the patient continues to reside at home but commutes to a treatment center up to seven days a week. This service model focuses on the overall treatment of the individual and is intended to avert or reduce in-patient hospitalization. Services are typically provided in either a hospital setting or by a free-standing community mental health center. Treatment during a typical day may include group therapy, psych-educational groups, skill building, individual therapy, and psychopharmacological assessments, and check-ins. Programs are available for the treatment of alcoholism and substance abuse, Alzheimer's disease, anorexia and bulimia, depression, bipolar disorder, anxiety disorders, schizophrenia, and other mental illnesses.

Participant: The employee or retiree or their enrolled spouse or domestic partner or dependent child(ren) or a surviving spouse or dependent of a retiree. NAC 287.095

Participating Provider: A health care provider who participates in the Plan's Preferred Provider Organization (PPO).

Passive Rehabilitation: Refers to therapy in which a patient does not actively participate because the patient does not have the ability to learn and/or remember (that is, has a cognitive deficit), or is comatose or otherwise physically or mentally incapable of active participation. Passive rehabilitation may be covered by the Plan, but only during a course of hospitalization for acute care. Techniques for passive rehabilitation are commonly taught to the family/caregivers to employ on an outpatient basis with the patient when and until the patient can achieve active rehabilitation. Continued hospitalization for the sole purpose of providing passive rehabilitation will not be medically necessary for the purposes of this Plan.

Pharmacy: A licensed establishment where covered prescription drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he or she practices.

Pharmacist: A person legally licensed under the laws of the state or jurisdiction where the services are rendered, to prepare, compound and dispense drugs and medicines, and who acts within the scope of his or her license.

Physical Therapy: Rehabilitation directed at restoring function following disease, injury, surgery, or loss of body part using therapeutic properties such as active and passive exercise, cold, heat, electricity, traction, diathermy, and/or ultrasound to improve circulation, strengthen muscles, return motion, and/or train/retrain an individual to perform Activities of daily living such as walking and getting in and out of bed.

Physician: A person legally licensed as a Medical Doctor (MD) or Doctor of Osteopathy (DO) and authorized to practice medicine, to perform surgery, and to administer drugs, under the laws of the state or jurisdiction where the services are rendered who acts within the scope of his or her license.

Physician Assistant (PA): A person legally licensed as a physician assistant, who acts within the scope of his or her license and acts under the supervision of a physician to examine patients, establish medical diagnoses; order, perform and interpret laboratory, radiographic and other diagnostic tests; identify, develop, implement and evaluate a plan of patient care; prescribe and dispense medication within the limits of his or her license; refer to and consult with the supervising physician; under the laws of the state or jurisdiction where the services are rendered.

Plan, The Plan, This Plan: In most cases, the programs, benefits, and provisions described in this document as provided by the Public Employees' Benefits Program (PEBP).

Plan Administrator: The person or legal entity designated by the Plan as the party who has the fiduciary responsibility for the overall administration of the Plan.

Plan Year: Typically, the 12-month period from July 1 through June 30. PEBP has the authority to revise the Plan Year if necessary. PEBP has the authority to revise the benefits and rates, if necessary, each Plan Year. For medical, dental, vision and pharmacy benefits, all Deductibles, Out-of-Pocket Maximums and Plan Year maximum benefits are determined based on the Plan Year.

Plan Year Deductible: The amount you must pay each Plan Year before the Plan pays benefits.

Plan Year Maximum Benefits: The maximum amount of benefits payable each Plan Year for certain medical expenses incurred by any covered Plan participant (or covered family member of the Plan participant).

Podiatrist: A person legally licensed as a Doctor of Podiatric Medicine (DPM) who acts within the scope of his or her license and who is authorized to provide care and treatment of the human foot (and in some states, the ankle and leg up to the knee) under the laws of the state or jurisdiction where the services are rendered.

Positive Annual Open Enrollment Period: This process requires that each eligible employee or eligible retiree affirmatively make his or her benefit elections during the PEBP annual enrollment period. Even if you do not want to make any coverage changes, you must affirmatively make your elections, or you will be defaulted to self-coverage only under the PEBP base Plan.

Pre-Admission Testing: Laboratory tests and x-rays and other medically necessary tests performed on an outpatient basis, 7 days prior to a scheduled hospital admission or outpatient surgery. The testing must be related to the sickness or injury.

Precertification (preauthorization, prior authorization): Is a process used by the UM company and Pharmacy Benefit Manager to determine if a prescribed procedure, including, but not limited to inpatient admission, concurrent review, DME, outpatient services, or medication are medically necessary before the services and supplies are received. A precertification is not a guarantee of payment.

Preferred Provider Organization (PPO): A group or network of health care providers (e.g., hospitals, physicians, laboratories) under contract with the Plan to provide health care services and supplies at agreed-upon discounted or reduced rates.

Prescribed for a Medically Necessary Indication: The term medically necessary indication means any use of a covered outpatient drug which is approved under the Federal Food, Drug and Cosmetic Act, or the use of which is supported by one or more citations included or approved for inclusion in any of the following compendia: American Hospital Formulary Service Drug Information, United States Pharmacopeia-Drug Information, the DRUGDEX Information System or American Medical Association Drug Evaluations.

Prescription Drugs: For the purposes of this Plan, prescription drugs include:

- Federal Legend Drugs: Any medicinal substance that the Federal Food, Drug, and Cosmetic Act requires to be labeled, "Caution - Federal law prohibits dispensing without prescription".
- Other prescription drugs: drugs that require a prescription under state law but not under federal law; or
- Compound drugs: Any drug that has more than one ingredient and at least one of them is a Federal Legend Drug or a drug that requires a prescription under state law.

Prescription Prior Authorization (PA): Also known as "coverage review," this is a process the Plan's Pharmacy Benefit Manager might use to decide if your prescribed medicine will be covered. The Plan uses this to help control costs and to ensure the medicine being prescribed is an effective treatment for the condition.

Primary Care Physician (PCP): A physician in family practice, internal medicine, obstetrics and gynecology and pediatrics.

Prognathism: The malposition of the bones of the jaw resulting in projection of the lower jaw beyond the upper part of the face.

Program: Means the Public Employees' Benefits Program established in accordance with NRS 287.0402 to 287.049, inclusive.

Prophylactic Surgery: A surgical procedure performed for (1) avoiding the possibility or risk of an illness, disease, physical or mental disorder or condition based on genetic information or genetic testing, or (2) treating the consequences of chromosomal abnormalities or genetically transmitted characteristics, when there is an absence of objective medical evidence of the presence of disease or physical or mental disorder, even at its earliest stages. An example of prophylactic surgery is a mastectomy performed on a woman who has been diagnosed as having a genetic predisposition to breast cancer or has a history of breast cancer among her family members when, at the time the surgery is to be performed, there is no objective medical evidence of the presence of the disease, even if there is medical evidence of a chromosomal abnormality or genetically transmitted characteristic indicating a significant risk of breast cancer coupled with a history of breast cancer among family members of the woman.

Prophylaxis: The removal of tartar and stains from the teeth. The cleaning and scaling of the teeth are performed by a dentist or dental hygienist.

Prospective Payment System (PPS): This Plan follows CMS's Prospective Payment System (PPS) where the Plan's payment is based on a predetermined, fixed amount payable to a facility for inpatient or outpatient hospital services. The Plan will not allow separate reimbursement for specific HCPCS supplies, DME, orthotics, prosthetics, biological, and drugs billed on a HCFA claim form by any physician or other qualified healthcare professional in the following facility POS (place of service) 19, 21, 22, 23, and 24, see the following POS descriptions:

- **POS 19 Off Campus – Outpatient Hospital:** A portion of an off-campus hospital provider-based department which provides diagnostic, therapeutic (both surgical and non-surgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.
- **POS 21 Inpatient Hospital:** A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and nonsurgical), rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.
- **POS 22 On Campus – Outpatient Hospital:** A portion of a hospital's main campus which provides diagnostic, therapeutic (both surgical and non-surgical), and rehabilitation services by, or under, the supervision physicians to patients admitted for a variety of medical conditions.
- **POS 23 Emergency Room – Hospital:** A portion of a hospital where emergency diagnosis and treatment of illness and injury is provided.
- **POS 24 Ambulatory Surgery Center:** A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.

Prosthetic Appliance (or Device): A type of corrective appliance or device designed to replace all or part of a missing body part, including (but not limited to) artificial limbs, heart pacemakers, or corrective lenses needed after cataract surgery. See also the definitions of Corrective Appliances, Durable Medical Equipment, Nondurable Supplies and Orthotic Appliance (or Device).

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Provider: A health care practitioner as defined above, or a hospital, ambulatory surgical facility, behavioral health treatment facility, birthing center, home health care agency, hospice, skilled nursing facility, or sub-acute care facility (as those terms are defined in this *Key Terms and Definitions* Section).

Qualified Medical Child Support Orders (QMCSO): QMCSOs are state court orders requiring a parent to provide medical support to a child often because of legal separation or divorce, and also include a National Medical Support Notice. A QMCSO may require the Plan to make coverage available to your child even though, for income tax or Plan purposes, the child is not your dependent. To qualify, a medical support order must be a judgment, decree, or order (including approval of a settlement agreement) issued by a court of competent jurisdiction or by an administrative agency, which:

- Specifies your last known name and address and the child's last known name and address.
- Describes the type of coverage to be provided, or how the type of coverage will be determined.
- States the period to which it applies; and
- Specifies each plan to which it applies.

The QMCSO cannot require the Plan to cover any type or form of benefit that they do not currently cover. The Plan must pay benefits directly to the child, or to the child's custodial parent or legal guardian, consistent with the terms of the order and Plan provisions. You and the affected child will be notified if an order is received.

Qualifying Payment Amount (QPA) means the amount calculated using the methodology described in 29 CFR 716-6(c).

Quantity Limit: The maximum amount of a medication the Plan covers during a period of time. These limits are set for safety reasons and to help reduce costs.

Reasonable and/or Reasonableness: Means charges for services or supplies which are necessary for the care and treatment of an illness or injury. The determination that charges are reasonable will be made by the Plan Administrator taking into consideration the following:

- The facts and circumstances giving rise to the need for the service or supply.
- Industry standards and practices as they are related to similar scenarios; and
- The cause of the injury or illness necessitating the service or charge.

The Plan Administrator's determination will consider but will not be limited to evidence-based guidelines, and the findings and assessments of the following entities: (a) The National Medical Associations, Societies, and Organizations; (b) The Centers for Medicare and Medicaid Services (CMS); (c) Centers for Disease Control and Prevention; and (d) The Food and Drug Administration.

To be reasonable, charges must follow generally accepted billing practices for unbundling or multiple procedures. The Plan Administrator retains discretionary authority to determine whether a charge is reasonable. The Plan reserves for itself and parties acting on its behalf the right to review charges processed and/or paid by the Plan, to identify charges that are not reasonable and therefore not eligible for payment by the Plan.

Recognized Amount: means (in order of priority) one of the following:

1. An amount determined by an applicable All-Payer Model Agreement under section 1115A of the Social Security Act;
2. An amount determined by a specified state law; or
3. The lesser of the amount billed by the provider or facility or the Qualifying Payment Amount (QPA)

For air ambulance services furnished by Non-PPO providers, **Recognized Amount** is the lesser of the amount billed by the provider or facility or the Qualifying Payment Amount (QPA).

Reconstructive Surgery: A medically necessary surgical procedure performed on an abnormal or absent structure of the body to correct damage caused by a congenital birth defect, an accidental

injury, infection, disease, or tumor, or for breast reconstruction following a total or partial mastectomy.

Reference Based Pricing/Reference Price: A methodology that determines the cost for a covered service based on a market or industry benchmark or reference price. The Plan Administrator may utilize this method in determining the Maximum Allowable Charge.

Rehabilitation Therapy: Physical, occupational, or speech therapy that is prescribed by a physician when the bodily function has been restricted or diminished as a result of illness, injury or surgery, with the goal of improving or restoring bodily function by a significant and measurable degree to as close as reasonably and medically possible to the condition that existed before the injury, illness or surgery, or medically necessary treatment of a behavioral health condition, and that is performed by a licensed therapist acting within the scope of his or her license. See the *Schedule of Medical Benefits* and the *Exclusions* section of this document to determine the extent to which rehabilitation therapies are covered. See also the definition of Physical Therapy, Occupational Therapy, Speech Therapy and Cardiac Rehabilitation.

Reimbursable Payments: Payments made by this Plan for benefits, including any payment for a covered pre-existing condition that are or become the responsibility of another party under the subrogation provisions as described in this MPD.

Rescission: A cancellation or discontinuance of coverage under the Plan that has a retroactive effect. Rescission does not include a cancellation or discontinuance of coverage under the Plan if (a) The cancellation or discontinuance of coverage has only a prospective effect; or (b) The cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

Retiree: Unless specifically indicated otherwise, when used in this document, Retiree refers to a person formerly employed by an agency or entity that may or may not participate in the PEBP program and who is eligible to enroll for coverage under this Plan.

Retrognathism: The malposition of the bones of the jaw resulting in the retrogression of the lower jaw from the upper part of the face.

Retrospective Review: Review of health care services after they have been provided to determine if those services were medically necessary and/or if the charges for them are Usual and Customary Charges and do not exceed the Plan's Maximum Allowable Charge or negotiated fee schedule.

Second Opinion: A consultation and/or examination, preferably by a board-certified physician not affiliated with the primary attending physician, to evaluate the medical necessity and advisability of undergoing surgery or receiving a medical service.

Serious and Complex Condition: With respect to a participant, beneficiary, or enrollee under the Plan one of the following:

1. in the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm;
2. in the case of a chronic illness or condition, a condition that is—
   a. is life-threatening, degenerative, potentially disabling, or congenital; and
   b. requires specialized medical care over a prolonged period of time.

Service Area: The geographic area serviced by the In-Network providers who have agreements with the Plan's network.

Sickle Cell Disease: An inherited disease caused by a mutation in a gene for hemoglobin in which red blood cells have an abnormal crescent shape that causes them to block small blood cells and die sooner than normal red blood cells and may include sickle cell disease, one or more variants or a combination thereof, as applicable. See also NRS 439.4927.

Significantly Inferior Coverage: The PEBP Board has defined Significantly Inferior Coverage as either:

- A mini-med or other limited benefit plan; or
- Catastrophic coverage plans with a Deductible equal to or greater than $5,000 for single coverage with no employer contributions to a Health Savings Account or Health Reimbursement Arrangement.

Skilled Nursing Care: Services performed by a licensed nurse (RN, LVN or LPN) if the services are ordered by and provided under the direction of a physician; and are intermittent and part-time, generally not exceeding 16 hours a day, and are usually provided on less-than-daily basis; and require the skills of a nurse because the services are so inherently complex that they can be safely and effectively performed only by or under the supervision of a nurse. Examples of skilled nursing care services include but are not limited to the initiation of intravenous therapy and the initial management of medical gases such as oxygen.

Skilled Nursing Facility or Extended Care/Skilled Nursing Facility: A public or private facility, licensed and operated according to law, that primarily provides skilled nursing and related services to people who require medical or nursing care and that rehabilitates injured, sick people or people with disabilities, and that meets all the following requirements:

- Is licensed pursuant to state and local laws.
- Is operated primarily for providing skilled nursing care and treatment for individuals convalescing from injury or illness.
- Is approved by and is a participating facility with Medicare.
- Has organized facilities for medical treatment.

- Provides 24-hour-a-day nursing service under the full-time supervision of a physician or registered nurse.
- Maintains daily clinical records on each patient.
- Has available the services of a physician under an established agreement.
- Provides appropriate methods for dispensing and administering drugs and medicines.
- Has transfer arrangements with one or more hospitals; a utilization review plan in effect; and operational policies developed with the advice of and reviewed by a professional group including at least one physician; and
- Is not an institution which is mainly a rest home; a home for the aged; a place for drug addicts; a place for alcoholics; or a place for the treatment of mental illness.

A skilled nursing facility that is part of a hospital, as defined in this document, will be considered a skilled nursing facility for the purposes of this Plan.

Special Food Product: [NRS 689B.0353] A food product that is specially formulated to have less than one gram of protein per serving and is intended to be consumed under the direction of a physician for the dietary treatment of an inherited metabolic disease. The term does not include a food that is naturally low in protein.

Specialist Physician: A doctor who has completed advanced education and training in a specific field of medicine.

Specialty Care Unit: A section, ward, or wing within a hospital that offers specialized care for the patient's needs. Such a unit usually provides constant observation, special supplies, equipment, and care provided by Registered nurses or other highly trained personnel. Examples include Intensive Care Units (ICU) and Cardiac Care Units (CCU).

Speech Therapy: Rehabilitation directed at treating defects and disorders of spoken and written communication.

Spinal Manipulation / Chiropractic Care: The detection and correction, by manual or mechanical means, of the interference with nerve transmissions and expressions resulting from distortion, misalignment, or dislocation of the spinal (vertebrae) column. Spinal manipulation is commonly performed by chiropractors, but it can be performed by physicians.

Spouse: The employee's lawful spouse. The Plan will require proof of the legal marital relationship. A legally separated spouse or divorced former spouse or domestic partner of an employee or retiree is not an eligible spouse under this Plan.

Standard Plan Benefits (Standard Benefits): Standard Plan Benefits or Standard Benefits under this Plan means the participant is covered under the Plan's Standard Benefits and is not eligible for enhanced benefits due to non-participating and or engaging in programs such as the Obesity Care and Overweight Management Programs.

State: When capitalized in this document, the term State means the State of Nevada.

Step Therapy: A process designed to help control high medicine costs. If the Plan applies step therapy to your medication, it will require that you try a lower-cost medication that is proven effective to treat your condition, before it will cover a higher-cost medicine. If the lower cost medicine does not treat your condition effectively, the Plan's coverage will "step" you to a higher-cost medicine to find a medicine that treats your condition effectively at the lowest possible cost.

The Plan also complies with NRS 689B.0305 and NRS 695C.17333.

Sub-acute Care Facility: A public or private facility, either free-standing, hospital-based or based in a skilled nursing facility, licensed and operated according to law and authorized to provide sub-acute care, that primarily provides, immediately after or instead of acute care, comprehensive inpatient care for an individual who has had an acute illness, injury, or exacerbation of a disease process, with the goal of discharging the patient after a limited term of confinement, to the patient's home or to a suitable skilled nursing facility, and that meets all of the following requirements:

1. It is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) as a Sub-Acute Care Facility or is recognized by Medicare as a Sub-Acute Care Facility; and
2. It maintains on its premises all facilities necessary for medical care and treatment; and
3. It provides services under the supervision of physicians; and
4. It provides nursing services by or under the supervision of a licensed Registered Nurse; and
5. It is not (other than incidentally) a place for rest, domiciliary care, or care of people who are aged, alcoholic, blind, deaf, drug addicts, mentally deficient, or suffering from tuberculosis; and
6. It is not a hotel or motel.

Substance Abuse: A psychological and/or physiological dependence or addiction to alcohol or drugs or medications, regardless of any underlying physical or organic cause, and/or other drug dependency as defined by the current edition of the ICD manual or identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM). See the definitions of behavioral health disorders and chemical dependency.

Surgery/Surgeries: Any operative or diagnostic procedure performed in the treatment of an injury or illness by instrument or cutting procedure through an incision or any natural body opening. When more than one surgical procedure is performed through the same incision or operative field or at the same operative session, the claims administrator will determine which multiple surgical procedures will be considered as primary, secondary, bilateral, add-on, or separate (incidental) procedures for determining benefits under this Plan.

Multiple Surgical Procedure Allowances:

- Primary procedure, bilateral primary procedure, or add-on to primary procedure: usual and customary, subject to the Plan's Maximum Allowable Charge or negotiated fee.
- Secondary procedure in same operative area: limited to 50% of usual and customary charge, subject to the Plan's Maximum Allowable Charge or negotiated fee.
- Bilateral secondary procedure in same operative area: limited to 50% of usual and customary charge, subject to the Plan's Maximum Allowable Charge or negotiated fee.
- Add-on to secondary procedure in same operative area: limited to 100% of usual and customary charge, subject to the Plan's Maximum Allowable Charge or negotiated fee.
- Separate (incidental) procedure in same operative area as any of the above: not covered.
- Separate operative area: limited to 50% of usual and customary charge, subject to the Plan's Maximum Allowable Charge or negotiated fee.

Telehealth: Telehealth means the delivery of services from a provider of health care to a patient at a different location using information and audio-visual communication technology, not including facsimile, or electronic mail. See also NRS 629.515

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Telehealth is a general term used to describe clinical services provided to patients through electronic communications not through a vendor. This can be patient-to-physician. Examples include patient consultation with a specialist that is out of the patient's geographical area or patient has a virtual visit with their primary care physician. Telehealth is the use of digital information and communication technologies, such as computers and mobile devices, to access health care services remotely and manage your health.

Telemedicine: Telemedicine (vendor/virtual visit) is the practice of medicine using technology to deliver care at a distance via electronic communications through a vendor.

Temporomandibular Joint (TMJ), Temporomandibular Joint (TMJ) Dysfunction or Syndrome: The Temporomandibular (or craniomandibular) Joint (TMJ) connects the bone of the temple or skull (temporal bone) with the lower jawbone (the mandible). TMJ Dysfunction or Syndrome refers to a variety of symptoms where the cause is not clearly established, including (but not limited to) masticatory muscle disorders producing severe aching pain in and about the TMJ (sometimes made worse by chewing or talking); myofascial pain, headaches, earaches, limitation of the joint, clicking sounds during chewing; tinnitus (ringing, roaring, or hissing in one or both ears) and/or hearing impairment. These symptoms may be associated with conditions such as malocclusion (failure of the biting surfaces of the teeth to meet properly), ill-fitting dentures, or internal derangement of the TMJ.

Termination: Under the No Surprises Act, **i**ncludes, with respect to the Continuation of Care benefit, the expiration or nonrenewal of the contract, but does not include a termination of the contract for failure to meet applicable quality standards or for fraud.

Therapist: A person trained in and skilled in giving therapy in a specific field of health care such as occupational, physical, radiation, respiratory and speech therapy. *See the Occupational, Physical and Speech Therapy* section.

Tortfeasor: Means an individual or entity who commits a wrongful act, either intentionally or through negligence, that injures another or for which the law provides a legal right through a civil case for the injured person to seek relief.

Transplant, Transplantation: The transfer of organs (such as the heart, kidney, liver) or living tissue/cells (such as bone marrow, stem cells or skin) from a donor to a recipient with the intent to maintain the functional integrity of the transplanted organ or tissue in the recipient. (See the *Schedule of Medical Benefits* and *Exclusions* section for additional information regarding transplants. See also the *Utilization Management* section of this document for information about precertification requirements for transplantation services).

Xerographic: Refers to transplants of organs, tissues, or cells from one species to another (for example, the transplant of an organ from a baboon to a human). Xerographic transplants are not covered by this Plan, except heart valves.

Urgent Care: Health care services that are required by the onset of a medical condition that manifests itself by symptoms of sufficient severity that prompt medical attention is appropriate, even though health and life are not in jeopardy. Examples of medical conditions that may be appropriate for urgent care include (but are not limited to) fever, sprains, bone, or joint injuries, continuing diarrhea, or vomiting, or bladder infections.

Urgent Care Claim: Means a claim for benefits that is treated in an expedited manner because the application of the time periods for making determinations that are not urgent care claims could seriously jeopardize the participant's life, health, or the ability to regain maximum function by waiting for a routine appeal decision. An urgent care claim also means a claim for benefits that, in the opinion of a physician with knowledge of the participant's medical conditions, would subject the participant to severe pain that cannot be adequately managed without the care or the treatment that is the subject of the claim. If an original request for precertification of an urgent care service was denied, the participant could request an expedited appeal for the urgent care claim.

Urgent Care Facility: A public or private hospital-based or free-standing facility, that includes x-ray and laboratory equipment and a life support system, licensed or legally operating as an urgent care facility, primarily providing minor emergency and episodic medical care with one or more physicians, nurses, and x-ray technicians in attendance when the facility is open.

Usual and Customary: Covered expenses which are identified by PEBP, taking into consideration the fee(s) which the provider most frequently charges (or accepts for) most patients for the service or supply, the cost to the provider for providing the services, the prevailing range of fees

charged in the same “area” by providers of similar training and experience for the service or supply, and the Medicare reimbursement rates. The term(s) “same geographic locale” and/or “area” shall be defined as a metropolitan area, country, or such greater area as is necessary to obtain a representative cross- section of providers, persons or organizations rendering such treatment, services, or supplies for which a specific charge is made.

To be Usual and Customary, fee(s) must follow generally accepted billing practices for unbundling or multiple procedures.

The term “Usual” refers to the amount of a charge made or accepted for medical services, care, or supplies, to the extent that the charge does not exceed the common level of charges made by other medical professionals with similar credentials, or health care facilities, pharmacies, or equipment suppliers of similar standing, which are in the same geographic locale in which the charge is incurred.

The term “Customary” refers to the form and substance of a service, supply, or treatment provided in accordance with generally accepted standards of medical practice to one individual, which is appropriate for the care or treatment of the same sex, comparable age and who receive such services or supplies within the same geographic locale.

The term “Usual and Customary” does not necessarily mean the actual charge made nor the specific service or supply furnished to a participant by a provider of services or supplies, such as a physician, therapist, nurse, hospital, or pharmacist. The Plan Administrator will determine what the Usual and Customary charge is, subject to the Plan’s Maximum Allowable Charge or negotiated fee schedule for any procedure, service, or supply, and whether a specific procedure, service or supply is usual and customary. Usual and customary charges may, at the Plan Administrator’s discretion, alternatively be determined and established by the Plan using normative data such as, but not limited to, Medicare cost to charge ratios, Average Wholesale Price (AWP) for prescriptions and/or manufacturer’s retail pricing (MRP) for supplies and devices.

Utilization Management (UM): A managed care process to determine the medical necessity, appropriateness, location, and cost-effectiveness of health care services. This review can occur before, during or after the services are rendered and may include (but is not limited to): precertification; concurrent and/or continued stay review; discharge planning; retrospective review; case management; hospital or other health care provider bill audits; and health care provider fee negotiation. Utilization management services (sometimes referred to as UM services, UM, utilization review services, UR services, utilization management, concurrent review, or retro review services) are provided by licensed health care professionals employed by the utilization management company operating under a contract with the Plan.

Utilization Management Company (UM company): The independent utilization management organization, staffed with licensed health care professionals, who utilize nationally recognized health care screening criteria along with the medical judgment of their licensed health care

professional, operating under a contract with the Plan to administer the Plan's utilization management services.

Visit: See the definition of office visit.

Well Baby Care; Well Child Care: Health care services provided to a healthy newborn or child that are determined by the Plan to be medically necessary, even though they are not provided because of illness, injury, or congenital defect. The Plan's coverage of well-baby care is described under *Preventive Care/Wellness Services* and in the *Schedule of Medical Benefits*.

You, Your: When used in this document, these words refer to the employee or retiree who is covered by the Plan. They do not refer to any dependent of the employee or retiree.

NEVADA PUBLIC EMPLOYEES' BENEFITS PROGRAM

Access.
Quality.
Affordability.

EXCLUSIVE PROVIDER ORGANIZATION MASTER PLAN DOCUMENT

Plan Year 2024

(Effective July 1, 2023 – June 30, 2024)

Public Employees' Benefits Program
901 S. Stewart Street, Suite 1001
Carson City, Nevada 89701

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Amendment Log

Any amendments, changes or updates to this document will be listed here. The amendment log will include what sections are amended and where the changes can be found.

Welcome PEBP Participant

Welcome to the State of Nevada Public Employees' Benefits Program (PEBP). PEBP offers medical, vision, dental, and life insurance, in addition to flexible spending accounts, and other voluntary benefits for eligible state and local government employees, retirees, and their eligible dependents.

As a PEBP participant, you may access whichever benefit plan offered in your geographical area that best meets your needs, subject to specific eligibility and plan requirements. These plans include the Consumer Driven Health Plan (CDHP) with a Health Savings Account (HSA) or a Health Reimbursement Arrangement (HRA), Exclusive Provider Organization Plan, Low Deductible PPO Plan, and the Health Plan of Nevada HMO Plan. You are also encouraged to research plan provider access and quality of care in your service area.

All PEBP participants choosing the Exclusive Provider Organization (EPO) should examine this document, the PEBP Self-Funded PPO Dental Plan Master Plan Document (MPD), the Active Employee Health and Welfare Wrap Plan, Retiree Health and Welfare Wrap Plan, Section 125 Document, and the PEBP Enrollment and Eligibility Master Plan Document. These documents are available at www.pebp.state.nv.us or by calling 775-684-7000, 702-486-3100, or 1-800-326-5496.

Master Plan Documents are a comprehensive description of the benefits available to you. Relevant statutes and regulations are noted in the Active Employee Health and Welfare Plan Document and Retiree Health and Welfare Wrap Plan Document for reference. In addition, helpful material is available from PEBP or any PEBP vendor listed in the *Participant Contact Guide*.

PEBP encourages you to stay informed of the most up to date information regarding your health care benefits. It is your responsibility to know and follow the requirements as described in PEBP's Master Plan Documents.

Sincerely,
Public Employees' Benefits Program

Introduction

This Master Plan Document describes the Exclusive Provider Organization (EPO) Plan. This Plan is available to eligible employees, retirees and their dependents participating in the Public Employees' Benefits Program, hereafter referred to as PEBP.

The Exclusive Provider Organization Plan is a self-funded plan administered by PEBP and governed by the State of Nevada. The benefits offered with the Exclusive Provider Organization Plan includes medically necessary behavioral health, medical, prescription drug, vision, and dental coverage. Additional benefits include basiclife insurance for active employees and eligible retirees. The medical and prescription drug benefits are described in this document. The dental benefits are described in the PPO Dental PlanMaster Plan Document. An independent third-party Claims Administrator pays the claims for medical, dental and vision benefits. An independent Pharmacy Benefit Manager pays the claimsfor prescription drug benefits.

This document is intended to comply with the Nevada Revised Statutes (NRS) Chapter 287, and the Nevada Administrative Code (NAC) 287 as amended and certain provisions of NRS 695G and NRS 689B. The Plan Sponsor certifies that this article incorporates the provisions set forth in 45 CFR Section 164.504(f)(2)(ii) and the Plan Sponsor agrees to such provisions in accordance with 45 CFR Section 164.504(f)(2)(ii).

The Plan described in this document is effective **July 1, 2023**, and unless stated differently, replaces all other Exclusive Provider Organization Plan medical and prescription drug benefit plan documents/summary plan descriptions provided to you. This document will help you understand and use the benefits provided by PEBP. You should review it and show it to members of your family who are or will be covered by the Plan. It will give you an understanding of the coverage provided, the procedures to follow in submitting claims and your responsibilities to provide necessary information to the Plan. Be sure to read the *Benefit Limitations and Exclusions* and *Key Terms and Definitions* sections. Remember, not every expense you incur for health care is covered by this Plan. All provisions of this document contain important information. If you have any questions about your coverage or your obligations under the terms of the Plan, please contact PEBP at the number listed in the *Participant Contact Guide* section.

PEBP intends to maintain this Plan indefinitely, but reserves the right to terminate, suspend, discontinue, or amend the Plan at any time and for any reason. As the Plan is amended from time to time, you will be sent information explaining the changes. If those later notices describe a benefit or procedure that is different from what is described here, you should rely on the later information. Be sure to keep this document, along with notices of any Plan changes, in a safe and convenient place where you and your family can find and refer to them**.**

Per NRS 287.0485 no officer, employee or retiree of the State has any inherent right to benefits provided under thePEBP.

Suggestions for Using this Document:

This document provides important information about your benefits. We encourage you to pay attention to the following:

- The Table of Contents provides you with an outline of the sections.
- The *Participant Contact Guide* helps you become familiar with PEBP vendors and services they provide.
- The *Participant Rights* section describes your rights and responsibilities as a participant of this Plan.
- The *Key Terms and Definitions* explains many technical, medical, and legal terms that appearin the text.
- The *Eligible Medical Expenses* and *Non-Eligible Medical Expenses*, *Summary of Medical Benefits* and *Schedule of Medical Benefits*, and *Benefit Limitations and Exclusions* sections describe your benefits in more detail.
- The Preventive Services wellness information that can help you proactively manage your health.
- The *Utilization Management* section provides information on what health care services require precertification and the process to request precertification.
- The *Claims Administration* section describes how benefits are paid and how to file a claim.
- The *Appeals Procedure* section describes how to request a review (appeal) if you are dissatisfied with a claims decision.
- The *Coordination of Benefits* section describes situations where you have coverage under more than one health care plan, including Medicare

Accessing Other Benefit Information:

You will also want to access the following documents for information related to dental, life, flexible spending accounts, enrollment and eligibility, Consolidated Omnibus Budget Reconciliation Act (COBRA), third-party liability and subrogation, Health Insurance Portability and Accountability Act (HIPAA) and Privacy and Security and mandatory notices. These documents are available at www.pebp.state.nv.us.

- State of Nevada PEBP Active Employee Health and Welfare Wrap Plan
- State of Nevada PEBP Retiree Health and Welfare Wrap Plan
- Consumer Driven Health Plan (CDHP) Master Plan Document
- CDHP Summary of Benefits and Coverage for Individual and Family
- Low Deductible PPO Plan Master Plan Document
- PEBP PPO Dental Plan and Summary of Benefits for Life Insurance Master Plan Document
- Exclusive Provider Organization Plan Master Plan Document
- Exclusive Provider Organization Plan Summary of Benefits and Coverage for Individual

and Family

- Health Plan of Nevada Evidence of Coverage (EOC) and Summary of Benefits and Coverage
- PEBP Enrollment and Eligibility Master Plan Document
- Flexible Spending Accounts (FSA) Summary Plan Description
- Section 125 Health and Welfare Benefits Plan Document
- Medicare Retiree Health Reimbursement Arrangement Summary Plan Description

Participant Rights

You have the right to:

- Participate with your health care professionals in your health care decisions and have your health care professionals give you information about your condition and your treatment options.
- Receive the benefits for which you have coverage.
- Be treated with respect and dignity.
- Privacy of your personal health information, consistent with State and Federal laws, and the Plan's policies.
- Receive information about the Plan's organization and services, the Plan's network of health care professionals and providers and your rights and responsibilities.
- Candidly discuss with your physicians and providers appropriate or medically necessary care for your condition, regardless of cost or benefit coverage.
- Make recommendations regarding the organization's participants' rights and responsibilities policies.
- Express respectfully and professionally, any concerns you may have about PEBP or any benefit or coverage decisions the Plan, or the Plan's designated administrator, makes.
- Refuse treatment for any conditions, illness, or disease without jeopardizing future treatment and be informed by your physician(s) of the medical consequences.

Summary of the EPO Plan Components

The Exclusive Provider Organization (EPO) Plan is a PEBP administered plan which provides In-Network benefits. As a member, you receive coverage for many medically necessaryservices and supplies, subject to any limits or exclusions in the Plan. However, apart from exceptional circumstances, such as emergent care and urgent care, this Plan only covers services when accessing Exclusive Provider Organization Plan providers within the network.

Highlights of the Plan

- This Plan is available to participants residing in the following northern Nevada counties: Carson City, Churchill, Douglas, Elko, Eureka, Humboldt, Lander, Lincoln, Lyon, Mineral, Pershing, Storey, Washoe, and White Pine.
- This Plan provides open access to most specialists within the northern Nevada area. With open access, participants can see In-Network specialist care physicians without an Out of Area gap exception.
- **This Plan is a northern Nevada regional plan and does not provide coverage outside of 14 counties** listed in on the first point without an Out of Area gap exception unless the health care services are rendered as part of an emergency room visit, urgent care visit, or when the requested treatment is prior authorized by the utilization management company.
- Covers eligible preventive care services at 100% when using In-Network providers (refer tothe *Preventive Services* section for more information); and
- Provides access to In-Network medical and prescription drug coverage.
- Provides a Plan Year Individual and Family Deductible and Out-of-Pocket Maximum for Eligible Medical Expenses.
- Health care resources and tools to assist you in making informed decisions about your and your family's health care services. For more information log onto your E-PEBP portal accountat www.pebp.state.nv.us.

Plan Year Deductibles and Out-of-Pocket Maximums		
	In-Network Deductible	**In-Network Out-of-Pocket Maximum**
Individual (self-only coverage)	$100	$5,000
Family	Family: $200 Individual family member: $100	Family: $10,000 Individual family Member: $5,000

In-Network and Out-of-Network Deductibles and Out-of-Pocket Maximums are not interchangeable.

Note: Deductible and Out-of-Pocket Maximums are for In-Network only; this plan does not provide Out-of-Network benefits except urgent and emergent care.

Deductibles

The Plan Year Deductibles (combined medical and specialty drugs) include two tiers:

- **Individual Deductible**: Applies when only one person is covered on the Plan (self-only coverage).
- **Family Deductible**: Applies when two or more individuals are covered on the same Plan (e.g., Employee plus Spouse, Employee plus Spouse and Child, etc.). The Family Deductiblemay be met through a combination of Eligible Medical Expenses from all covered family members. The In-Network Family Deductible includes an embedded "Individual Family Member" Deductible. This means one single family member is only required to meet the Individual Family Member Deductible before the Plan starts to pay Coinsurance for that member.

The Individual and Family Deductibles start July 1st (the first day of the Plan Year) and reset the following Plan Year on July 1st. This Plan does not include a Deductible carryover or rollover provision.

During the Plan Year, you are responsible for paying for your eligible medical and prescription drug expenses (except eligible Preventive Services provided In-Network), including amounts exceeding the Plan's reference-based pricing for hip and knee replacement, preauthorization penalties, out of pocket.

In-Network Individual Deductible

The In-Network Individual Deductible applies when only one person is covered on the Plan. For this Plan Year, the Deductible is **$100**. Participants are responsible for paying Out-of-Pocket for eligible medical and prescription drug expenses that are subject to the Deductible. Once the Individual Deductible is met, the Plan will pay its cost-share of eligible benefits. Deductible credit is based on the date the medical or prescription drug expense is received by the Plan and not on the date of service.

In-Network Family Deductible

The In-Network Family Deductible applies when two or more individuals are covered on the same Plan. For this Plan Year, the Family Deductible is **$200** and includes a **$100** embedded "Individual Family Member" Deductible. For a participant covered with one or more dependents, this Plan will pay benefits for eligible In-Network medical and prescription drug expenses for the entire family after the **$200** Family Deductible is met; or the Plan will pay benefits for one single family member who has met the **$100** "Individual Family Member" Deductible (under no circumstances

will one single family member be required to pay more than **$100** toward the **$200** Family Deductible). The **$200** In-Network Family Deductible may be met by any combination of Eligible Medical Expenses from *two or more* covered individuals in the family. Deductible credit is based on the date the medical or prescription drug expense is received by the Plan and not on the date of service.

Coinsurance

Coinsurance is the percentage of costs that generally you and the Plan pay for Eligible Medical Expenses after your Deductible is met. If you receive covered health care services using a health care provider who is a participating provider of this Plan's EPO network, you will be paying less money out of your pocket. This Plan generally pays **80%** of the In-Network provider's contract rate and you are responsible for paying the remaining **20%**. For Specialty Pharmacy expenses, the Plan generally pays **80%** and the participant pays **20%** for specialty drugs.

Copayments

Copayments apply as specifically stated in this document and are payable by the covered participant. Copayments do not apply to the Deductible but do apply to the Out-of-Pocket Maximum

Out-of-Pocket Maximum

The Plan Year In-Network Out-of-Pocket Maximum (OOPM) is the maximum amount a participant will pay for In-Network Eligible Medical and Prescription Drug Expenses during the Plan Year. Copayments, Deductible, and Coinsurance for Eligible Medical Expenses apply to the OOPM. The OOP Maximum for:

- An Individual (covered as self-only) is **$5,000**
- Family coverage (participant plus one or more covered dependents) is **$10,000**
    - The Family OOP Maximum includes a **$5,000** embedded "Individual Family Member" OOP Maximum. An Individual Family Member OOP Maximum means one single family member will not pay more than **$5,000** in the Plan Year for Eligible Medical Expenses.

The OOPM does not include premiums, cost-sharing for non-covered supplies and services, expenses associated with denied claims, ancillary charges, and penalties, and Out-of- Network charges, including emergent and urgent services that exceed the Plan's Maximum Allowable Charge. This list is not all inclusive and does may not include all services and supplies that do not apply to the OOPM.

For this section only, all references to the OOPM, Eligible Medical Expenses, Copayments, Deductibles and Coinsurance are specific to In-Network benefits, including benefits for Out-of-Network urgent and emergent services which are generally applied as an In-Network benefit, subject to the Plan's Maximum Allowable Charge, except where prohibited by law.

Out-of-Network urgent and emergent care providers are paid at the Maximum Allowable Charge,

except where prohibited by law.

Description of In-Network and Out-of-Network

This section includes information about how in-network and out-of-network benefits work and how emergency health services are covered.

The Plan only provides in-network benefits (refer to the *Summary of Medical Benefits* and *Schedule of Medical Benefits* and the *Benefit Limitations and Exclusions* sections for more information). In-network benefits are payable for covered expenses which are:

- Provided by an in-network physician or other in-network provider; or
- Considered to be an out-of- network benefit exception.

Payment for in-network benefits is based on the in-network provider's negotiated rate as established by the network.

The Plan Administrator or its designee arranges for providers to participate in a network. In-network providers are independent practitioners.

The credentialing process confirms public information about the provider's licenses and other credentials but does not assure the quality of the services provided. Before obtaining services, you should always verify the network status of a provider. A provider's status may change. You are responsible for verifying a provider's network status prior to receiving services, even when you are referred by another in-network provider.

It is possible that you might not be able to obtain services from an in-network provider. You also might find that an in-network provider may not be accepting new patients. If a provider leaves the network or is otherwise not available to you, you must choose another in-network provider to get in-network benefits.

Do not assume that an in-network provider's agreement includes all covered expenses. Some in-network providers agree to provide only certain covered expenses, but not all covered expenses. Some in-network providers choose to be an in-network provider for only some products. You may contact the Claims Administrator for assistance in choosing a provider or with questions about a provider's network participation.

Provider Network

The Plan or its designee arranges for providers to participate in a network. For more information, see the Participant Contact Guide section of this document. In-Network providers are hospitals, physicians, medical laboratories, and other health care providers located within a service area who have agreed to provide health care services and supplies at negotiated discount fees. Network providers are not the Plan's employees or employees of any Plan designee.

The contracted Network is responsible for credentialing providers by confirming public information about the providers' licenses and other credentials but does not assure the quality

of the services provided.

Before obtaining services, you should always verify the network status of a provider. A provider's status may change. You are responsible for verifying a provider's network status prior to receiving services, even when you are referred by another In-Network provider. You can verify the provider's status by calling the third-party administrator or on the PEBP website in the Find a Provider section. The provider listing is maintained and updated by the contracted network.

It is possible that you might not be able to obtain specific services from an In-Network provider. The provider network is subject to change. Or you might find that an In-Network provider may not be accepting new patients. If a provider leaves the network or is otherwise not available, you must choose another In-Network provider to get In-Network benefits.

Do not assume that an In-Network provider's agreement includes all Eligible Medical Expenses. Some In-Network providers agree to provide only certain covered expenses, but not all covered expenses. Some In-Network providers choose to be an In-Network provider for only some products and services. You may contact the third-party administrator for assistance in choosing a provider or with questions about a provider's network participation.

In-Network Provider Benefits

The Plan provides In-Network benefits when the services are provided by an In-Network provider. In-Network benefits are payable for Eligible Medical Expenses.

When a participant uses the services of an In-Network health care provider, the participant is responsible for paying the applicable Copay, Deductible, and Coinsurance on the discounted fees for medically necessary services or supplies, subject to the Plan's coverage, limitations, and exclusions.

If you receive medically necessary services or supplies from an In-Network provider, you will pay a lower Coinsurance than if you received those services or supplies from a health care provider who is not in the EPO network (Out-of-Network). In-Network providers have agreed to accept the Plan's payment (plus any applicable Coinsurance you are responsible for paying) as payment in full. The In-Network health care provider generally deals with the Plan directly for any additional amount due.

Out-of-Network Benefits

Out-of-Network (non-network) health care providers have no agreements with the Plan and are generally free to set their own charges for the services or supplies they provide.

Out-of-network benefits are not provided under this Plan except as specified in the *Summary of Medical Benefits, Schedule of Medical Benefits, Utilization Management* and *Benefit Limitations and Exclusions* sections and when prohibited by law, such as the No Surprises Act.

Out-of-Network Benefit Exceptions

There is an exception for emergent or urgent care or without services being approved in advance

by the Plan's utilization management company.

Emergency Care

The Plan provides benefits for emergency care when required for stabilization and initiation of treatment as provided by or under the direction of a physician. Eligible Medical Expenses that are provided as a result of Urgent or Emergent care provided by In-Network providers are paid at the In-Network benefit level. Out-of-Network Urgent and Emergent care for Eligible Medical Expenses are paid at the In-Network benefit level, subject to the Plan's Maximum Allowable Charge and the No Surprises Act.

Confinement in an Out-of-Network Hospital Following an Emergency

If you are confined in an Out-of-Network hospital after you receive emergency services, the utilization management company must be notified within two business days or on the same day of admission if reasonably possible. The UM company may elect to transfer you to an In-Network hospital as soon as it is medically appropriate to do so. If you choose to stay in the Out-of-Network hospital after the date the utilization management company decides a transfer is medically appropriate, and the provider obtains informed consent, and you receive the required notice as required under the No Surprises Act. Providers may bill the participant for any balance that may be due in addition to the amount paid by the Plan (called balance billing).

Other Exceptions

If you receive ancillary services such as an x-ray, laboratory services, or anesthesia services from an Out-of-Network provider while receiving services at an In-Network inpatient or outpatient facility (such as an outpatient surgery center), the Plan will cover the *Eligible Medical Expenses* at the In-Network benefit level, subject to the Plan's Maximum Allowable Charge. Services subject to the No Surprises Act are subject to the Recognized Amount.

Other Providers

If you have a medical condition that the Claims Administrator or the UM company believes needs special services, they may direct you to a provider chosen by them. If you require certain complex covered services for which expertise is limited, the Claims Administrator or the UM company may direct you to an out-of-network provider.

In both cases, benefits will only be paid if your covered expenses for that condition are provided by the provider chosen by the Claim's Administrator or the UM company.

Eligible Medical Expenses

You are covered for expenses you incur for most, but not all, medical services, and supplies. The expenses for which you are covered are called eligible medical expenses. Eligible medical expenses are limited to the covered benefits specified in the *Summary and Schedule of Medical Benefits* and are:

- Determined by the Plan Administrator or its designee to be medically necessary (unless otherwise stated in this Plan), but only to the extent that the charges are Usual and Customary (U&C), provided in-network, do not exceed the Plan's Maximum Allowable Charge, costs that do not exceed the Plan's reference-based pricing for services performedat exclusive facilities; (as those terms are defined in the *Key Terms and Definitions* section of this document);
- Are not excluded from coverage under this Plan; and
- The health care benefits, services and supplies are not in excess of the limited overall, lifetime and/or Plan year maximum benefits.

Generally, the Plan will not reimburse you for all eligible medical expenses. Usually, you will have to pay some portion of costs, known as cost-sharing such as copayments or coinsurance toward the amounts you incur that are eligible medical expenses. However, you are only required to pay copayments and coinsurance for eligible medical expenses up to the Plan year individual or family out-of-pocket maximum.

The above is not all inclusive. For more information regarding eligible medical expenses, see the *Summary of Medical Benefits and Schedule of Medical Benefits, Key Terms and Definitions, Benefit Limitations and Exclusions* sections.

Non-Eligible Medical Expenses

You are responsible for paying the full cost of all expenses that are not Eligible Medical Expenses, including expenses that are:

- Not determined to be medically necessary (unless otherwise stated in this Plan).
- Determined to be in excess of the usual and customary charges.
- Determined to be in excess of the Plan's Maximum Allowable Charge.
- Expenses for medical services or supplies that are not covered by the Plan, including, but not limited to, expenses that exceed the EPO provider contract rate, services listed in the *Exclusions* section of this document and dental expenses.
- Benefits exceeding those services or supplies subject to limited overall maximums for each covered individual for certain *Eligible Medical Expenses*.
- Additional amounts you are required to pay because of a penalty for failure to comply with the Plan's utilization management requirements described in the *Utilization Management* section of this document. If you fail to follow certain requirements of the Plan's utilization management program, the Plan may pay a smaller percentage of the cost of those services, and you may have to pay a greater percentage of those costs. The additional amount you may have to pay is in addition to your Deductibles or Out-of-Pocket Maximums described in the tables.
- *Preventive Care/Wellness Services* that are paid by the Plan at 100% do not accumulate towards the Out-of-Pocket Maximum.
- Received Out-of-Network services except emergent and urgent care, or without services being approved in advance by the Plan's utilization management company.

With exception of services subject to the No Surprises Act, Out-of-network providers may bill you their standard charges and any balance that may be due after the Plan payment. It is the participant's responsibility to verify the In-Network status of a chosen provider.

For more information regarding non-eligible medical expenses, see the *Benefit Limitations and Exclusions* section.

Health Reimbursement Arrangement

PEBP and its HRA vendor require direct deposit for HRA reimbursements.

Active Employees

This section provides summary information only. For more detailed information regarding this important benefit, see Internal Revenue Service (IRS) Publication 502 or contact the HRA third-party claims administrator listed in the *Participant Contact Guide*.

PEBP will be funding an HRA for active employees enrolled in a qualifying PEBP plan for Plan Year 2024~~in this Plan on July 1, 2023~~. **This is a one-time event.**

Funds in the HRA account may be used to pay for qualified medical expenses as defined by the IRS (see IRS Publication 502), other than premiums, including payment of Deductibles, Coinsurance, and other Out-of-Pocket qualifying healthcare expenses not covered by this Plan.

The HRA may only be used to pay or reimburse qualified Out-of-Pocket health care expenses incurred by the following individuals enrolled in this Plan (or other non-HRA group health coverage providing minimum value):

- the participant; or
- the participant's spouse; or
- participant's dependent(s) who could be claimed on the participant's annual tax return.

HRA funds may not be used for a person who does not meet the IRS definition of a qualified tax dependent, including many domestic partners, children of domestic partners and older children who cannot be claimed on the participant's tax return, regardless of whether PEBP provides coverage for the dependent.

The entire annual PEBP one-time contribution for **Plan Year 2024** will be available for use at the beginning of the Plan Year on or about **July 1, 2023** (subject to certain limitations). Participants who initially elect PEBP coverage after July 1, 2023, will receive a pro-rated base contribution for the participant based upon the coverage effective date and the months remaining in the Plan Year. Participants cannot contribute to an HRA. If the annual funds in the HRA are exhausted, neither PEBP nor the participant will contribute any additional funds.

Any funds remaining in the HRA at the end of the Plan Year will carryover (i.e., will not be forfeited) and will be available for use in the following Plan Year as long as the member maintains the same Plan.

Participants are allowed the option annually, and at termination in the plan, to permanently opt-out of the HRA, and thereby forfeit any unused balance.

Unlike a Flexible Spending Account (FSA), participants cannot be reimbursed from funds that are not yet available in the HRA. Any reimbursement from the HRA will be the lesser of the available

HRA balance or the claim amount paid to the provider.

HRA funds are not portable between different plan types; participants cannot use HRA funds if they are no longer covered by the initial Plan with an HRA. If a participant terminates their coverage, the remaining balance in the HRA account will revert to PEBP, unless the qualified beneficiary elects COBRA. Participants enrolled with an HRA who change plans during the Open Enrollment period or during a Qualifying Life Event to a plan with an HSA and retirees who transition coverage to the Medicare Exchange will forfeit any remaining funds in the HRA account.

Active employees who retire and who are not Medicare age (typically at age 65 years) can maintain the balance of their HRA account at retirement if:

- They are eligible to enroll in and continue coverage under a PEBP plan; or
- Continue coverage under COBRA.
    - If a participant elects COBRA coverage, the HRA account will remain in place until COBRA coverage is terminated.

In the case of a retroactive coverage termination, any funds used from the HRA for expenses that are incurred after the date of coverage termination will be recovered by PEBP through the collection process.

Retirees who have a HRA balance and who transition to the Medicare Exchange will forfeit any remaining funds in the HRA on the last day of coverage under this Plan.

The death of an active employee or retiree will cause any remaining funds in the HRA to be forfeited on the first day following the date of death.

Timely Filing of HRA Claims

In accordance with NAC 287.610, all claim requests must be submitted to the third-party claims administrator within one year (12 months) from the date of service that the claim is incurred. No plan benefits will be paid for any claim requests submitted after this period.

When your HRA-eligible coverage ends, you will have one year (12-months) from the date your coverage ends to file a claim for reimbursement from your HRA for eligible claims incurred during your coverage period in accordance with NAC 287.610. HRA funds may not be used to pay premiums.

HRA Contributions for Eligible Active Employees and Retirees

Employee	One-Time Contribution
Participant Only	***$300**

*HRA contribution provided to eligible active employees enrolled in a Plan on **July 1, 2023**. For

Plan Year 2024, dependents are not eligible for PEBP HRA contributions.

Under no circumstances will a participant who received contributions during the Plan Year be eligible for additional contributions due to reinstatement of coverage or changing plans.

Utilization Management

The Plan is designed to provide you and your eligible dependents with financial protection from significant health care expenses. To enable the Plan to provide coverage in a cost-effective way, it has a Utilization Management (UM) program designed to help control increasing health care costs by avoiding unnecessary services, directing participants to more cost-effective treatments capable of achieving the same or better results and managing new medical technology and procedures. If you follow the procedures of the Plan's UM program, you may avoid some Out-of-Pocket costs. However, if you do not follow these procedures, Plan benefits are reduced, and you will be responsible for paying more out of pocket.

The Plan's UM program is administered by an independent professional UM company operating under a contract with the Plan. The name, address and telephone number of UM company appears in the *Participant Contact Guide* section. The health care professionals at the UM company focus their review on the medical necessity of hospital stays and the medical necessity, appropriateness, and cost-effectiveness of proposed medical or surgical services. In carrying out its responsibilities under the Plan, the UM company has been given discretionary authority by the Plan administrator to determine if a course of care or treatment is medically necessary with respect to the patient's condition and within the terms and provisions of the Plan.

The UM program is not intended to diagnose or treat medical conditions, validate eligibility for coverage, or guarantee payment of Plan benefits. Eligibility for and actual payment of benefits are subject to the terms and conditions of the Plan as described in this document, PEBP's *Employee Health and Welfare Wrap Plan, and Retiree Health and Welfare Wrap Plan* documents. For example, benefits would not be payable if your eligibility for coverage ended before the services were rendered, or if the services were not covered, either in whole or in part, by an exclusion in the Plan.

Regardless of whether your physician recommends surgery, hospitalization, confinement in a skilled nursing or sub-acute facility, or your physician or other provider proposes or provides any medical service or supply does not mean the recommended services or supplies will be considered medically necessary for determining coverage under the Plan.

Benefits payable by the Plan may be affected by the determination of the UM company. If:

- The UM company does not authorize a proposed surgery or other proposed medical treatment as medically necessary; or
- The Plan will not pay regular benefits for a hospitalization or confinement in a skilled nursing or sub-acute facility because the UM company does not authorize a proposed confinement.

PEBP, the third-party claim administrator, and the UM company are not engaged in the practice of medicine and are not responsible for the outcomes of health care services rendered (even if the health care services have been authorized by the UM company as medically necessary), or

for the outcomes if the patient chooses not to receive health care services that have not been authorized by the UM company as medically necessary.

When reviewing services for appropriateness of care and medical necessity, the UM company uses guidelines and criteria published by nationally recognized organizations, along with medical judgement of licensed heath care professionals.

Delivery of Services

You are entitled to receive medically necessary medical care and services as specified in this Plan's *Schedule of Medical Benefits*. These include medical, mental health, behavioral health, surgical, diagnostic, therapeutic, and preventive services. If a precertification is required and you do not obtain the required precertification, the service may not be covered, even if the service is medically necessary. These services, although not all inclusive are those that generally:

- Are provided In-Network,
- Are performed or ordered by a participating provider,
- Require a precertification according to the utilization management and quality assurance protocols, if applicable.

Concurrent Review

Concurrent Review (continued stay) is the ongoing assessment of the health care as it is being provided, especially (but not limited to) inpatient confinement in a hospital or skilled nursing or sub-acute facility. When you are receiving medical services in a hospital or other inpatient facility, the UM company monitors your stay by contacting your physician or other providers to assure that continuation of medical services in the facility are medically necessary. The UM company will also help coordinate your medical care with other healthcare benefits available under the Plan.

Concurrent review may include such services as coordinating home health care or durable medical equipment, assisting with discharge plans, determining the need for continued medical services, and or advising your physician or other providers of various options and alternatives for your medical care available under this Plan.

If at any point, your stay is found not to be medically necessary and care could be safely and effectively delivered in another environment (such as through home health care or in another type of health care facility), you and your physician will be notified. This does not mean that you must leave the hospital, but if you choose to stay, all expenses incurred after the notification will be your responsibility. If your hospital stay is determined not to be medically necessary, no benefits will be paid on any related hospital, medical or surgical expense. You may also appeal the determination (refer to the *Appealing a UM determination* section).

Retrospective Review

The review of health care services after they have been provided to determine if those services

were medically necessary. The Plan will pay benefits only for those days or treatment that would have been authorized under the utilization management program; and case management: The process whereby the patient, the patient's family, physician, or other providers work together with the Plan Administrator or its designee under the guidance of the UM company to coordinate a quality, timely and cost-effective treatment plan.

Case Management

Case management is a voluntary process administered by the UM company. Its medical professionals work with the patient, the patient's family, caregivers, providers, the third-party claims administrator, and the Plan Administrator or its designee to coordinate a timely and cost-effective treatment program. Case management services are particularly helpful when the patient needs complex, costly and/or high-technology services, or when assistance is needed to guide the patient through a maze of potential providers. Case management is available for individuals diagnosed with sickle cell or its variants, among other conditions (NRS 695G.174).

The case manager will work directly with your physician, hospital, and/or other provider to review proposed treatment plans and to assist in coordinating services and obtaining discounts from providers as needed. From time to time, the case manager may confer with your physician or other providers and may contact you or your family to assist in making plans for continued health care services or obtaining information to facilitate those services.

You, your family, or your physician may call the case manager at any time to ask questions, make suggestions or offer information. The case manager can be reached by calling the UM company at the telephone number shown in the *Participant Contact Guide* section or on the PEBP website at www.pebp.state.nv.us.

Precertification (Prior Authorization) Process

Precertification prior authorization review is a procedure administered by the UM company to assure health care services meet or exceed accepted standards of care. In certain cases, as set forth below, for a benefit to be covered, the UM company must approve and/or pre-certify the service**. If a precertification is required and you do not obtain the required precertification, benefits may be reduced, even if the service is medically necessary.** The UM company uses nationally recognized guidelines and criteria as standard measurement tools to determine whether benefits are approved and/or pre-certified.

Precertification also includes the determination of whether the admission and length of stay in a hospital or skilled nursing or sub-acute facility, surgery or other health care services are medically necessary and if the location of service is high quality and lowest cost.

A precertification is required for referrals to physicians and providers for certain services. All benefits listed in this Plan may be subject to precertification requirements and concurrent or retrospective review depending upon the circumstances associated with the services. Refer to the Services Requiring Precertification section below for more information.

Failure to obtain precertification may result in your benefits being reduced or denied (see the *Failure to Follow Required Utilization Management Procedures* in this section).

Services Requiring Precertification (Prior Authorization)

All Inpatient Admissions

- Acute; observation; and same day surgeries
- Long-Term Acute Care
- Rehabilitation
- Behavioral health
- Transplant including all pre-transplant related expenses
- Skilled Nursing facility and sub-acute facility
- Residential Treatment Facility, including outpatient partial hospitalization programs, and partial residential treatment programs
- Hospice (inpatient/outpatient) exceeding 185 days
- Obstetric – (precertification only required if days exceed 48 hours for vaginal delivery or 96 hours for a C-section)
- Intraoperative Neuro Monitoring

Outpatient and Physician - Surgery

- Back Surgeries and hardware related to surgery
- Total and remaining Hip and Knee Surgeries
- Biopsies (excluding skin, colonoscopy and upper GI endoscopy biopsy, upper GI endoscopy diagnosis)
- Thyroidectomy, Partial or Complete
- Open Prostatectomy
- Oophorectomy, unilateral and bilateral
- Hysterectomy (including prophylactic)
- Autologous chondrocyte implantation, Carticel
- Transplant (excluding cornea)
- Balloon sinuplasty
- Surgeries to treat Gender Dysphoria
- Bariatric/weight loss surgeries at Centers of Excellence and adjustments to lap bands after the first 12 months post-surgery
- Sleep apnea related surgeries, limited to:
  - Radiofrequency ablation (Coblation, Somnoplasty)
  - Uvulopalatopharyngoplasty (UPPP) (including laser-assisted procedures)
- Mastectomy (including gynecomastia and prophylactic) and reconstruction surgery
- Orthognathic procedures (e.g., Genioplasty, LeFort osteotomy, Mandibular ORIF, TMJ)
- Varicose vein surgery/sclerotherapy
- Prophylactic surgery

- Any procedure deemed to be Experimental and/or Investigational (provider must indicate on the pre-certification request that the service/procedure is Experimental and/or Investigational and/or part of a clinical trial)
- Intraoperative Neuro Monitoring

- Prophylactic surgery

Outpatient and Physician – Diagnostic Services

- CT, PET, SPEC, and MRI
- Capsule endoscopy
- Genetic Testing (including BRCA)

Outpatient and Physician – Continuing Care Services

- Applied Behavior Analysis Therapy
- Dialysis
- Chemotherapy (including oral)
    - Oral Chemotherapy to be reviewed by Pharmacy Benefit Manager
- Radiation Therapy
- Oncology and transplant related injections, infusions, and treatments (e.g., CAR-T, endocrine and immunotherapy), excluding supportive drugs (e.g., antiemetic and antihistamine)
- Hyperbaric Oxygen
- Home Health Care
- Durable Medical Equipment exceeding $1,000
    - prior authorization is based on overall cost to the plan and/or purchase price, not the amount billed for monthly rental. DME rental to purchase in accordance with Medicare guidelines.
- Non-Emergency Medical Transportation – scheduled air and ground facility to facility and interstate
- Injectables and infusions excluding services reviewed by the PBM
- Behavioral Health Intensive Outpatient Program
- Sickle Cell Disease
- Vein Therapy
- Electroconvulsive Therapy (ECT)
- Transcranial Magnetic Stimulation (TMS)
- Habilitative and rehabilitative therapy (physical, speech, occupational) exceeding a combined visit limit of 90 visits per Plan Year

Services Not Requiring Precertification (Prior Authorization)

Prior authorization is not required for medically necessary emergency services when a medical condition that manifests itself by symptoms of such severity (including severe pain) that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect that the absence of immediate medical attention could result in:

- Serious jeopardy to the health of the participant.

- Serious jeopardy to the health of an unborn child.
- Serious impairment of a bodily function; or
- Serious dysfunction of any bodily organ or part.

The UM company must be notified of an emergency hospital admission within one business day so the UM company can conduct a *concurrent review*. Your physician or the hospital should call the UM company to initiate the concurrent review. Even though a precertification may not be required for some services, the hospital or facility is still required to comply with the Plan's provisions regarding UM, such as concurrent review.

How to Request Precertification (Prior Authorization)

It is your responsibility to ensure that precertification occurs when it is required by the Plan. Any penalty or denial of benefits for failure to obtain precertification is your responsibility, not the provider's. You or your physician must call the UM company at the telephone number shown in the ***Participant Contact Guide*** to request precertification. Calls for elective services should be made at least 15 calendar days before the expected date of service or may be subject to the benefit reduction listed in the ***Utilization Management*** section. The UM company will require the following information:

- The employer's name.
- Employee's name.
- Patient's name, address, phone number and Social Security Number or PEBP unique ID.
- Physician's name, phone number or address.
- The name of any hospital or outpatient facility or any other provider that will be providing services.
- The reason for the health care services or supplies; and
- The proposed date for performing the services or providing the supplies.

The UM company will review the information and provide a determination to you, your physician, the hospital or other provider, and the third-party claims administrator as to whether the proposed health care services have been determined to be medically necessary. Additionally, the UM company may approve medical necessity but not site of care. In these circumstances, the UM company will provide approved alternate locations to the caller. While industry and accreditation standards require a preauthorization determination within 15 calendar days for a non-urgent case, the UM company will usually respond to your physician or other provider by telephone within (5) five business days of receipt of the request. The determination will then be confirmed in writing.

If your hospital admission or medical service is determined not to be medically necessary, you and your physician will be given recommendations for alternative treatment. You may also pursue an appeal (refer to the *Appealing a UM Determination* section).

Second Opinion

The utilization management company may authorize a second opinion upon your request in accordance with this Plan. Examples of instances where a second opinion may be appropriate include:

- Your physician has recommended a procedure and you are unsure whether the procedure is necessary or reasonable.
- You have questions about a diagnosis or plan or care for a condition that threatens substantial impairment or loss of life, or bodily functions.
- You are unclear about the clinical indications about your condition.
- A diagnosis is in doubt due to conflicting test results.
- Your physician is unable to diagnose your condition; and a treatment plan in progress is not improving your medical condition within a reasonable period.

A participating provider, including your primary care physician, may notify the UM company on your behalf to obtain precertification (prior authorization) for the services described in Services Requiring Precertification (Prior Authorization)

Hospital Admission

You are responsible for ensuring the UM company is notified at least 5 (five) business days before an inpatient admission to obtain pre-certification.

Your physician or other provider may notify the UM company, but it is ultimately your responsibility to make sure they are notified. The UM company will review the physician/provider's recommendation and treatment plan to determine the level of care and place of service. If the UM company denies the precertification for hospital admission as not covered or they determine that the services do not meet the UM company's medical necessity criteria, the Plan's third-party administrator will only pay benefits for inpatient that has been pre-certified.

You are required to obtain a precertification before you obtain services for inpatient elective surgeries. If you do not follow the required UM process, benefits for the elective surgeries may be reduced by 50% of this Plan's Maximum Allowable Charge. This provision applies to both In-Network and Out-of-Network surgery expenses. Expenses related to the penalty will not be counted to meet your Out-of-Pocket Maximum, if applicable.

Emergency and Urgent Hospital Admission

This includes all complications of pregnancy
You are not required to obtain a precertification before you obtain services for a medical emergency. However, the UM company must still be notified within 24 hours, the next business day, or as soon as reasonable after admission so the UM company can conduct a concurrent review. If you are incapacitated and you (or a friend or relative) cannot notify the UM company within the above stated times, they must receive notification as soon as reasonably possible after the admission or you may be subject to reduction or denial of benefits as provided by the Plan.

- Emergency Hospital Admission: Admission for hospital confinement that results from a sudden and unexpected onset of a condition that requires medical or surgical care. In the absence of such care, you could reasonably be expected to suffer serious bodily injury or death. Examples of emergency hospital admission include, but are not limited to, admissions, for heart attacks, severe chest pain, burns, loss of consciousness, serious breathing difficulties, spinal injuries, and other acute conditions.
- An urgent hospital admission means an admission for a medical condition resulting from injury or serious illness that is less severe than an emergency hospital admission but requires care within a short time, including complications of pregnancy.

Even though a precertification may not be required for some services, the hospital or facility is still required to comply with the Plan's provisions regarding utilization management, such as concurrent review.

If you do not follow the required UM process, benefits payable for the services may be reduced by 50% of this Plan's Maximum Allowable Charge. Expenses related to the penalty will not be counted to meet your Out-of-Pocket Maximum.

Confinement in an Out-of-Network Hospital Following an Emergency Admission

Please refer to the No Surprises Act section of this document for claims subject to that Act. For all other confinements, if you are confined in an Out-of-Network hospital after you receive emergency services, the UM company must be notified within 24 hours, the next business day, or as soon as reasonable after admission. The UM company may determine it is appropriate to transfer you to an In-Network hospital as soon as it is medically appropriate to do so. If you choose to stay in the Out-of-Network hospital after the date the UM company decides a transfer is medically appropriate, the Plan will pay Eligible Medical Expenses at the Out-of-Network benefit level, subject to the Plan's Maximum Allowable Charge if the continued stay is authorized by the UM company and determined to be a covered service. Benefits for the continued stay will not covered under this Plan.

Other Exceptions

If you receive ancillary services such as an x-ray, laboratory services, or anesthesia services from an Out-of-Network provider while receiving services at an In-Network inpatient or outpatient facility (such as an outpatient surgery center), the Plan will cover the Eligible Medical Expenses at the In-Network benefit level, subject to the Plan's Maximum Allowable Charge.

Elective Knee and Hip Joint Replacement – Nevada Exclusive Hospitals and Outpatient Surgery Centers

Precertification is required; the UM company will review the request based on surgery type, medical necessity, covered benefits, provider quality, cost, and provider location.

Due to cost variations for elective knee and hip joint replacement performed in Nevada, the

third-party claims administrator has identified exclusive providers who meet the Plan's cost threshold for routine knee and hip replacement procedures. The exclusive provider list can be found on the PEBP website.

If you choose a provider on the exclusive list, you will potentially reduce your out-of-pocket costs in accordance with the standard plan benefits.

However, if you choose to use a non-exclusive provider, the Plan will pay benefits in accordance with its cost threshold or Maximum Allowable Charge. You may be subject to balance billing for any amount exceeding this Plan's cost threshold. Amounts exceeding the Plan's established threshold will not apply to your Deductible (if applicable) or Out-of-Pocket Maximum.

Inpatient or Outpatient Surgery

You are responsible for ensuring that the UM company is notified at least 5 (five) business days before elective inpatient or outpatient surgery is performed to ensure that it is covered.

Your physician or other provider may notify the UM company, but it is your responsibility to make sure they are notified. The UM company will review the physician's recommended course of treatment to ensure the requested treatment meets established medical necessity criteria and protocols.

The claims administrator will only pay benefits for inpatient or outpatient surgery that is pre-certified, and the services/supplies are a covered benefit.

Outpatient Infusion Services

Precertification is required for outpatient infusion services. The UM company will review the request based on covered benefits, medical necessity, provider quality, cost, and location. If you choose to receive your infusion at a non-exclusive hospital or infusion center, you will be responsible for any amount that exceeds this Plan's Maximum Allowable Charge. Amounts exceeding this Plan's established cost threshold will not apply to your annual Deductible or Out-of-Pocket Maximum.

Air Ambulance Services

This Plan provides coverage for emergency air ambulance and inter-facility patient air transport if there is a life-threatening situation, or the service is deemed medically necessary by the UM company. The air ambulance services are subject to the Plan Deductible, if applicable, then the Plan will pay the lower of the EPO allowable for In-Network air ambulance providers, or for Out-of-Network providers, the Plan will pay up to the Recognized Amount.

See the Utilization Management section for air ambulance precertification requirements.

Air/Flight Schedule Inter-Facility Transfer

All inter-facility transport services require precertification. The UM company may discuss with the physician and/or hospital/facility the diagnosis and the need for inter-facility patient

transport versus alternatives. Failure to obtain a precertification may result in a reduction or denial of benefits for charges arising from or related to flight-based inter-facility transfers. Non-compliance penalties imposed for failure to obtain a precertification will not be included as part of the annual out-of-pocket maximum.

Inter-facility transport may occur if there is a life-threatening situation, or the transport is deemed medically necessary. The following conditions apply:

- Services via any form of air/flight for inter-facility transfers must be pre-certified before transport of the participant to another hospital or facility, and the participant is in a hospital or other health care facility under the care or supervision of a licensed health care provider; and
- Inaccessibility to ground ambulance transport or extended length of time required to transport the patient via ground ambulance transportation could endanger the patient.

Emergency Air Ambulance

This Plan provides coverage for emergency air ambulance transportation for participants whose medical condition at the time of pick-up requires immediate and rapid transport due to the nature and/or severity of the illness/injury. Air ambulance transportation must meet the following criteria:

- Services via any form of air/flight for emergency air ambulance; and
- The patient's destination is an acute care hospital; and
- The patient's condition is such that the ground ambulance (basic or advanced life support) would endanger the patient's life or health; or
- Inaccessibility to ground ambulance transport or extended length of time required to transport the patient via ground ambulance transportation could endanger the patient.

See *Air Ambulance Services* for details on plan benefits and coverage.

Gender Dysphoria Related Services

The participant or their physician must contact the UM company to begin the process toward surgical intervention of gender dysphoria. The initial contact will include:

- Notification to the participant that the precertification process begins with the initial contact to the UM company.
- Coverage for procedures are based on the UM company's clinical policy for medical necessity; and
- Advising participants of providers who specialize in this type of treatment.

This service is provided by the UM company and will be initiated upon the first call for a precertification. Case management services are particularly helpful for a participant or their covered dependent who is receiving complex medical services for medical conditions such as

gender dysphoria. Your assigned case manager nurse will provide you with assistance with addressing any concerns you may have about issues such as, continuity of care or finding providers or a provider who specializes in gender dysphoria.

Health Care Services and Supplies Review

A participating provider, including your primary care physician, may notify the UM company on your behalf to obtain precertification (prior authorization) for the services described in *Services Requiring Precertification (Prior Authorization).*

Non-participating providers may not know to notify the UM company to obtain precertification for services. In such a case, you must confirm that the UM company pre-certified the service to assure that it is covered.

The Plan will pay for covered health care services and supplies only if authorized as outlined above. The Plan will not pay for any health care services or supplies that are not covered services or do not meet medically necessary criteria and protocols.

Failure to Follow Required Utilization Management Procedures

If you do not follow the required precertification review process described in this section, benefits payable for the services you failed to receive a precertification may be reduced by 50% of the Plan's Maximum Allowable Charge. This provision applies to both In-Network and Out-of-Network *Eligible Medical Expenses*. Expenses related to the penalty will not apply to your Plan Year Deductible or Out-of-Pocket Maximum. If you wish to appeal a decision made by the UM company, refer to the *Appealing a UM Determination* section.

Coronavirus (COVID-19) Pandemic Benefits

Coronavirus Aid, Relief, and Economic Security Act (Cares Act)
Benefits Apply during the Coronavirus Pandemic

The following benefits will be paid at 100% of the Maximum Allowable Charge, both, In-and Out-of-Network during the national public health emergency period.

- **COVID-19 Diagnostic Testing: virus/antigen detection (diagnostic) test determines if a person is currently infected with COVID-19. An antibody (serology) test may determine if a person may have been infected with the virus, and according to the FDA, antibody tests should not be used to diagnose current infection.**
  - **Medically appropriate, FDA-authorized, COVID-19 testing when ordered by a physician or health care professional for purposes of diagnosis or treatment.**
  - **Diagnostic testing is different than COVID-19 screening/surveillance testing.**
- **COVID-19 Related Diagnostic Testing Visit: COVID-19 testing related visits such as urgent care, emergency room, physician's office, telemedicine, and telehealth visits.**
- **COVID-19 Preventive Health Services: In accordance with the following, the Plan covers qualifying coronavirus disease 2019 (COVID-19) preventive services at 100% of the Plan's Maximum Allowable Charge for In-Network and Out-of-Network providers without any cost sharing (Copayment, Deductible, or Coinsurance):**
  - **An evidence-based item or service that has in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; or (B) An immunization that has in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC).**

- **Laboratory Services Related to Covid-19**
  - **COVID-19 Diagnostic Testing: virus/antigen detection (diagnostic) test determines if a person is currently infected with COVID-19. An antibody (serology) test may determine if a person may have been infected with the virus, and according to the FDA, antibody tests should not be used to diagnose current infection. Covid-19 Diagnostic Testing will be paid at 100% of the Maximum Allowable Charge, both, In and Out-of-Network in accordance with the CARES Act or until the last date of the national public health emergency period.**
  - **COVID-19 Screening/Surveillance Testing: COVID testing conducted for purposes other than diagnostic (including, but not limited to, employer mandated, travel, social/entertainment purposes) is not a covered benefit.**

All benefits are subject to cost-sharing unless otherwise stated.

Summary of Medical Benefits

To determine the benefit limitations for any health care service or supply, review the Summary and Schedule of Medical Benefits listed below.

To determine precertification requirements, refer to the *Utilization Management* section.

Copay applies to primary Care Physician (PCP) and Specialist office visits for evaluation and management services only; imaging, surgery, and other services provided during a PCP or Specialist office visit are subject to the Plan Year Deductible and Coinsurance.

Benefit Description	In-Network	Out-of-Network
Primary Care Physician Office Visit	$20 Copay	**Not Covered**
Specialist Services (including Allergy Services)	$40 Copay	**Not Covered**
No referral is required for these visits. ***Imaging, surgery, and all other services provided in an office setting subject to Deductible and Coinsurance.***		

Benefit Description	In-Network	Out-of-Network
Wellness/Preventive Office Visits and Preventive Screenings		
Primary Care ACA Wellness Visit	$0 Copay	**Not Covered**
Obstetrics and Gynecology ACA Services	$0 Copay	**Not Covered**
Prenatal and PostnatalOffice Visit	$0 Copay	**Not Covered**
No referral is required for these visits. ***Imaging, surgery, and all other services provided in an office setting subject to Deductible and Coinsurance.***		

Benefit Description	In-Network	Out-of-Network
Wellness/Preventive Office Visits and Preventive Screenings		
Mammography screening	$0 Copay	**Not Covered**
Limit: One preventative 2D or 3D mammogram screening per Plan Year for women aged 40 years and older or beginning at age 35 for members with a high-risk of breast cancer.		
Papanicolaou (Pap) test	$0 Copay	**Not Covered**
Prostate Specific Antigen (PSA) screening	$0 Copay	**Not Covered**
Colorectal screening	$0 Copay	**Not Covered**
Colorectal Screening: Starting at age 45 in accordance with the American Cancer Society's screening guidelines.		
Counseling for sexually transmitted infections (STI), HIV counseling and testing	$0 Copay	**Not Covered**
Breastfeeding support, supplies, and counseling	$0 Copay	**Not Covered**
Contact the third-party claims administrator for the purchase of covered breast pumps. Rental forheavy duty electrical (hospital grade) covered only when medically necessary and only during the newborn's inpatient hospital stay.		
Screening for interpersonal and domestic violence	$0 Copay	**Not Covered**
Contraceptives/In-office counseling	$0 Copay	**Not Covered**
FDA approved injections, implants, and contraceptive devices not covered under the pharmacy benefits.		
Screening for Gestational Diabetes	$0 Copay	**Not Covered**
High-risk Human Papillomavirus (HPV) testing	$0 copay	**Not Covered**

Real Appeal	$0 copay	**Not Covered**
For more information, refer to the Preventive Services in the Schedule of Medical Benefits section.An office visit copay may apply if services provided during the visit include additional services thatare not preventive services.		

Benefit Description	In-Network	Out-of-Network
Hospital Facility Services		
Elective Inpatient Hospital Admission	$600 Copay per Admission	**Not Covered**
Emergency Inpatient Hospital Admission	$600 Copay per Admission	**$750 Copay, subject to the Plan's Maximum Allowable Charge**
Inpatient Delivery Postpartum/Newborn Care Services	$600 Copay per Admission	**Not Covered**
Outpatient Observation	$600 Copay	**Not Covered**
Outpatient Observation period that lasts more than 23 hours will be considered and paid as an inpatient confinement.		
Outpatient Surgery	$350 Copay	**Not Covered**
Other services related to, and during, the outpatient surgery on that date are not subject to the deductible and coinsurance.		
Skilled Nursing Facility (Limited to 100 days per Plan Year)	$600 Copay per Admission	**Not Covered**
Rehabilitation, Habilitation Facility (Limited to 60 days per Plan Year)	$600 Copay per Admission	**Not Covered**
All hospital facility services require precertification. In emergencies in which a member is admittedto hospital for an inpatient stay, the UM company must be notified with 24 hours, the next business day following the admission. See the Utilization Management section for precertification requirements, including emergency hospital admissions.		

Benefit Description	In-Network	Out-of-Network
Urgent and Emergency Services		
Urgent Care Services*	$50 Copay	**$50 Copay, subject to the Plan's Maximum Allowable Charge and applicable law***
Emergency Room Services*	$600 Copay	**$600 Copay,**
Ambulance (ground/water)	Plan pays 80% after Deductible	**Plan Pays 80% after Deductible, subject to the Plan's Maximum Allowable Charge and applicable law**
Ambulance (air)	Plan pays 80% after Deductible	**Plan Pays 80% after Deductible, subject to the Plan's Maximum Allowable Charge and applicable law**

When using Out-of-Network ambulance providers you are responsible for paying your Copayment amount, Deductible, and Coinsurance, in addition to amounts exceeding the Plan's applicable Maximum Allowable Charge for air ambulances, including ground and water ambulance services. See the Utilization Management and Schedule of Medical Benefits for precertification requirements (inter-facility patient air transfer/transport), including the Maximum Allowable Charge for air ambulance. See Key Terms and Definitions for more information. Emergency Room services: If admitted to the hospital, the ER Copay is waived and theInpatient Hospital Copay applies.

***see also NRS 695G.170 for medically necessary emergency services at any hospital in Nevada.**

Benefit Description	In-Network	Out-of-Network
Outpatient Specialty Imaging and Diagnostic Testing		
Computer Tomography (CT) Scan	Plan pays 80% after Deductible	**Not Covered**
Positron Emission Tomography (PET) Scan	Plan pays 80% after Deductible	**Not Covered**
Magnetic ResonanceImaging (MRI/MRA)	Plan pays 80% after Deductible	**Not Covered**
Nuclear Medicine	Plan pays 80% after Deductible	**Not Covered**
Angiograms andMyelograms	Plan pays 80% after Deductible	**Not Covered**
See the Utilization Management section for precertification requirements.		

Benefit Description	In-Network	Out-of-Network
Non-Specialty Imaging and Diagnostic Testing **(Including X-rays and Ultrasounds; except Specialty Imaging and Diagnostic Testing)**		
Services provided in a Primary Care PhysicianOffice	Plan pays 80% after Deductible	**Not Covered**
Services provided in a Specialty Care Physician's Office	Plan pays 80% after Deductible	**Not Covered**
Services provided in a hospital outpatient setting	Plan pays 80% after Deductible	**Not Covered**
Diagnostic Mammography	**$40 Copay**	**Not Covered**

Benefit Description	In-Network	Out-of-Network
Laboratory Services		
General laboratory Services	Plan pays 80% after Deductible	**Not Covered**
Routine/Preventive Lab Testing*	Plan pays 80% after Deductible	**Not Covered**
Routine and Preventive Lab Services ***Routine/Preventive lab services must be performed at a freestanding non-hospital-based lab facility.*** ***Medically necessary routine labs when ordered by a physician as part of comprehensive medical care.*** ***Preventive laboratory services such as basic metabolic panel, lipid, or general health panel.*** ***Routine/preventive lab tests performed at an outpatient hospital or hospital-based free-standing facility/draw station are not covered.***		
Pre-admission Lab Testing Services**	Plan pays 80% after Deductible	**Not Covered**
Pre-Admission Lab Testing Services ****Pre-admission lab testing performed on an outpatient basis at a hospital-based lab or free-standing hospital-based lab draw station within 7 days prior to a scheduled hospital admission or outpatient surgery. Testing must be related to the sickness orinjury for which admission or surgery is planned.***		

Benefit Description	In-Network	Out-of-Network
Outpatient Short-Term Rehabilitation Services **Outpatient Speech, Occupational, and Physical Therapy**		
Speech Therapy	$40 Copay per Visit	**Not Covered**
Occupational Therapy	$40 Copay per Visit	**Not Covered**
Physical Therapy	$40 Copay per Visit	**Not Covered**
Precertification required; speech, occupational, and physical therapy visits are limited to a combined 90 visits per Plan Year.		

Benefit Description	In-Network	Out-of-Network
Other Outpatient Therapy and Rehabilitation Services		
Cardiac and Pulmonary rehabilitation	Plan pays 80% after Deductible	**Not Covered**
Limited to medically necessary services; 60 visits per Plan Year for all modalities combined.		
Dialysis	Plan pays 80% after Deductible	**Not Covered**
Wound Therapy	Plan pays 80% after Deductible	**Not Covered**
Chemotherapy Treatment	Plan pays 80% after Deductible	**Not Covered**
Radiation Therapy (Outpatient hospital, facility, or physician's office)	Plan pays 80% after Deductible	**Not Covered**
Infusion Therapy (home/outpatient, including specialty drugs)	Plan pays 70% after Deductible	**Not Covered**
See the Utilization Management section for all precertification requirements.		

Benefit Description	In-Network	Out-of-Network
Surgical Services		
Performed in a Primary Care Physician's office	Plan pays 80% after Deductible	**Not Covered**
Performed in a SpecialtyCare Physician's office	Plan pays 80% after Deductible	**Not Covered**
Performed in same-day surgery facility or Ambulatory Surgery Center (ASC)	$350 Copay	**Not Covered**
See the Utilization Management section for surgical services requiring precertification.		

Benefit Description	In-Network	Out-of-Network
Medical Supplies, Equipment, and Prosthetics		
Durable Medical Equipment (DME)	Plan pays 80% after Deductible	**Not Covered**
Durable Medical Equipment (DME): Limited to one purchase, repair, or replacement of a specific item of DME every 3 years. DME rental to purchase in accordance with Medicare guidelines. The purchase or rental of DME, including oxygen related equipment in excess of $1,000 requires precertification.		
Orthopedic and prosthetic devices	Plan pays 80% after Deductible	**Not Covered**
Orthopedic and prosthetic devices: Limited to a single purchase of a type of prosthetic device, including repair and replacement, every 3 years. Orthopedic and prosthetic devices in excess of $1,000 require precertification.		
Hearing Aids	$25 Copay per Device	**Not Covered**
Coverage for medically necessary, FDA approved air conduction hearing aids. Subject to a $25 Copay per device, Maximum benefit $1,500 per device, per each ear, every 3 years.		
Special Food Product	Plan pays 80% after Deductible	**Not Covered**
Special Food Product: $2,500 maximum benefit per Plan Year for the Special Food Products for the treatment of inherited metabolic diseases. See Enteral Formulas and Special Food Products in the Schedule of Medical Benefits.		
Enteral Formula	Plan pays 80% after Deductible	**Not Covered**
Enteral Formula for the treatment of inherited metabolic disease. See Enteral Formulas and Special Food Products in the Schedule of Medical Benefits.		

Benefit Description	In-Network	Out-of-Network
Mental/Behavioral Health Treatment		
Inpatient/Residential Rehabilitation	$600 Copay per Admission	**Not Covered**
Intensive Outpatient Treatment Program	$20 Copay per Visit	**Not Covered**

Partial Hospitalization Program	$600 Copay per Admission	**Not Covered**
Outpatient treatment	$20 Copay per Visit	**Not Covered**
Applied Behavioral Therapy	$20 Copay per Visit	**Not Covered**
Psychological testing	Plan pays 80% after Deductible	**Not Covered**

Refer to the Utilization Management section for precertification requirements.

Benefit Description	In-Network	Out-of-Network
Mental Health		
Inpatient medically necessary services for mental health disorders	$600 Copay per Admission	**Not Covered**
Mental health Outpatient Visit	$20 Copay per Visit	**Not Covered**

Inpatient admission requires precertification. Refer to the Utilization Management section formore information.

Benefit Description	In-Network	Out-of-Network
Other Medical Services Doctor on Demand, Telehealth, 2nd MD		
Doctor on Demand **Telemedicine Visit**		
Medical Visit	$10 Copay per Visit	**Not Covered**
Psychology Visit (25-minute visit)	$20 Copay per Visit	**Not Covered**
Psychologist Visit (50-minute visit)	$20 Copay per Visit	**Not Covered**

Psychiatrist Visit (45 minute/initial visit)	$20 Copay per Visit	**Not Covered**
Psychiatry Visit (15-minute follow-upvisit)	**$20 Copay per Visit**	**Not Covered**

Benefit Description	In-Network	Out-of-Network
Other Medical Services Doctor on Demand, Telehealth, 2nd MD		
Telehealth Visit		
Primary Care Visit	$20 Copay per Visit	**Not Covered**
Specialist Care Visit	$40 Copay per Visit	**Not Covered**
2nd.MD (Second Opinion Services)		
2nd.MD (Second Opinion Services)	**$0 Copay per Visit**	**Not Covered**

Benefit Description	In-Network	Out-of-Network
Other Medical Services		
Chiropractic (Spinal manipulation services)	$40 Copay per Visit	**Not Covered**
Chiropractic and spinal manipulation services: Limited to 20 office visits per Plan Year.		
Acupuncture, acupressure services	$40 Copay per Visit	**Not Covered**
Acupuncture and acupressure services: Limited to 20 visits (combined) per Plan Year, 100 visits (combined) per lifetime.		
Home Health Care	Plan pays 80% after Deductible	**Not Covered**

60 visits per Plan year; may provide for private duty nursing in thehome; requires precertification.

Benefit Description	In-Network	Out-of-Network
Other Medical Services		
Office-based infertility services	$40 Copay per Visit	**Not Covered**
Medically necessary services for subscriber, spouse, and/or domestic partner to diagnose problems of infertility for a covered individual (limited toone diagnostic evaluation for infertility every Plan Year, and up to three (3) per lifetime~~, and up tosix (6) artificial inseminations per lifetime~~. See exclusions in the Benefit Limitations and Exclusions.These limits and exclusions apply to both office-based and non-office-based infertility services. Forcost sharing for infertility services that are not performed in the office, see the applicable section in the Summary of Medical Benefits		
Temporomandibular Joint (TMJ) Disorder Services		
Office-based services (Excluding surgical services)	**Specialist Visit**: $40 Copay **Other office-based services**: Plan pays 80% after Plan Year Deductible.	**Not Covered**
TMJ Surgical Services	**Inpatient:** $600 Copay **Outpatient:** $350 Copay	**Not Covered**
TMJ disorder and dysfunction services and supplies including night guards are covered only whenthe required services are not recognized dental procedures. Limited to two (2) surgeries in a lifetime.		
Hospice	$600 Copay per Admission	**Not Covered**
The hospice care program administers palliative and supportive health care services providing physical, psychological, social, and spiritual care for terminally ill patients with a life expectancy of6 months or less as certified by patient's medical physician. For outpatient bereavement services, see Hospice Services in the Schedule of Medical Benefits. Precertification is required for both inpatient and outpatient hospice services exceeding 185 days. ***For a description of the hospice care benefits, see Hospice Services in the Schedule of Medical Benefits.***		

Benefit Description	In-Network	Out-of-Network
Obesity Care Management (OCM) Program **(Disease Management Program)**		
Weight Loss Medication	*Preferred Retail Network30-Day Supply	HomeDelivery 90-Day Supply
Preferred/Formulary Generic	$0 Copay	$0 Copay	**Not Covered**
Preferred/Formulary Brand	$20 Copay	$40 Copa	**Not Covered**
Non-Preferred/Non-Formulary Brand	$75 Copay	$150 Copay	**Not Covered**
Preferred Retail Network *Pharmacies: Copayments apply if you fill your prescription at a* Preferred Retail Network *pharmacy. If you fill your prescription at a non-*Preferred Retail Network *retail pharmacy, you will pay anadditional $10 per prescription. If you currently use a non-*Preferred Retail Network *pharmacy and you want to avoid the $10 upcharge, call a* Preferred Retail Network *pharmacy to transfer your prescription. See the Schedule of Pharmacy Benefits for instructions on how to find a* Preferred Retail Network *pharmacy. Certain weight loss* ***medications may not be available in 90-day supply. Contact Express Scripts for information aboutyour prescribed medication. * Retail 90-day Supply is three (3) times the copay for the 30-day supply		
Office Visit **(OCM weight loss provider)**	$0 Copay	**Not Covered**
Laboratory test	$0 Copay	**Not Covered**
Outpatient laboratory test services as determined by your weight loss provider (and as covered under this Plan). Outpatient laboratory tests must be performed at an in-network, free-standing, non-hospital based, lab facility such as Lab Corp or Quest.		

Benefit Description	In-Network	Out-of-Network
Obesity Care Management (OCM) Program **(Disease Management Program)**		
Nutritional Counseling Services	$0 Copay	**Not Covered**
Nutritional Counseling Services are covered for enrolled OCM participants who are actively engaged in the program. Nutritional counseling services must be provided by a registered dietician or nutritionist. The frequency of the nutritional counseling services will be determined by the third-party claims administrator and will be based on medical necessity and engagement in the OCM program.		
OCM benefitssubject to requirements/compliance with the OCM program as indicated in the Schedule ofMedical Benefits Section.		

Benefit Description	In-Network	Out-of-Network
Vision Care Services		
Vision Exam	$10 Copay	**$10 Copay**
Limited to one exam per Plan Year, per covered individual. The maximum benefit this Plan will pay per Plan Year, per covered individual is $100.		
Prescription eyeglasses	$10 Copay	**$10 Copay**
Single vision, bifocal and trifocal lenses, and prescription contact lenses. ***Eyeglasses, or contact lenses in lieu of eyeglasses, limited to $100 every 24 months.***		

Prescription Drug Benefits

In-Network Pharmacy Benefits

	Preferred Retail Network **Pharmacies*** (30-Day Supply)	**Smart90 Retail Pharmacies** (90-Day Supply)	**Home Delivery from Express Scripts Pharmacy (90-Day Supply)**
Preferred Formulary Generic	$10 Copay	$20 Copay	**$20 Copay**
Preferred Formulary Brand	$40 Copay	$80 Copay	**$80 Copay**
Non-Preferred/Non-Formulary Brand	$75 Copay	$150 Copay	**$150 Copay**

Specialty Drugs

Specialty Drugs Accredo Specialty Mail Order Pharmacy	**N/A**	**N/A**	**You pay 20% after PlanYear Deductible (30-Day supply)**

Benefit Description	In-Network	Out-of-Network
Hinge Health		
Digital Musculoskeletal (MSK) Care	**$0 Copay**	Not Covered

**** Pharmacies: Copayments apply if you fill your prescription at a pharmacy. If you fill your prescription at a non- retail pharmacy, you will pay an additional $10 per prescription. If you currently use a non-EAN pharmacy and you want to avoid the $10 upcharge, call a* Preferred Retail Network *pharmacy to transfer your prescription.***

Prescription drugs are not covered when purchased from Out-of-Network pharmacies.

See the Schedule of Medical Benefits in this document for important information related to pharmacy benefits, including how to find a Smart90 pharmacy.

Schedule of Medical Benefits

The Schedule of Medical Benefits provides a description of benefits, including certain limitations under this Plan. All covered services must be medically necessary and are subject to exclusions and limitations as described herein. Precertification is required for many services, plan benefit limitations apply to certain benefit categories, and out-of-network are not covered unless otherwise specified in this document.

When the Plan Administrator determines that two or more courses of treatment are substantially equivalent, the Plan Administrator reserves the right to substitute less costly services or benefits for those that this Plan would otherwise cover.

> *Example: If both inpatient care in a skilled nursing facility and intermittent, part-time nursing care in the home would be medically appropriate, and if inpatient nursing care would be less costly, this Plan could limit coverage to the inpatient care. This Plan could limit coverage to inpatient care even if this means extending the inpatient benefit beyond the quantity provided in the Summary of Medical Benefits or Schedule of Medical Benefits.*

The fact that a participating provider prescribed, ordered, recommended, or approved a service, treatment, or supply does not necessarily make it a covered service or medically necessary.

The *Summary of Medical Benefits and Schedule of Medical Benefits* should be read in conjunction with the *Benefit Limitations and Exclusions* and *Key Definitions Terms and Definitions*. The Explanations and Limitations may not include every limitation. For more information relating to a specific benefit, refer to *Utilization Management* (for any precertification requirements), *Exclusions*, *Key Terms and Definitions* and other sections that may apply to a specific benefit.

All claims must be submitted within twelve (12) months of the date of service to be considered for payment.

Acupuncture and Acupressure Services

Acupuncture and acupressure are covered under this Plan if performed by a licensed health care provider acting within the scope of their license. Acupuncture and acupressure services must be provided by In-Network and are limited to 20 visits per Plan Year, maximum 100 visits per lifetime.

Maintenance services are not a covered benefit.

Alcohol and Substance Abuse Services (inpatient and outpatient)

Medically necessary inpatient and outpatient alcohol and substance abuse services will be provided under the same terms as medical and surgical benefits, with no additional financial or treatment limitations. Substance abuse care benefits are for acute medical detoxification and for

substance abuse rehabilitation and counseling. The main purpose of medical detoxification is to rid the body of toxins, monitor heart rate, blood pressure and other vital signs, manage withdrawal symptoms and administer medications as needed. Inpatient and outpatient programs for alcohol and substance abuse treatment require precertification. Alcohol and substance abuse office visits that are not part of an alcohol or substance abuse program do not require precertification.

Allergy Testing and Treatment

Coverage is provided for medically necessary allergy testing, preparation of serum, serum, and administration of injections. For allergy treatment only, the participant will be responsible for the lesser of the primary care or specialist office visit copay or the cost of the serum/injection.

Ambulance Services

Ambulance services are covered if the services are medically necessary, and they are:

- Provided in an emergency; or
- Provided in a non-emergency setting when prior authorized by the UM company.

Autism Spectrum Disorders

This Plan provides coverage for autism spectrum disorder per NRS 695G.1645 including coverage of screening for and diagnosis of autism spectrum disorders and for the treatment of autism spectrum disorders for covered dependents individuals. Treatment of autism spectrum disorders must be identified in a treatment plan and may include medically necessary habilitative or rehabilitative care, prescription drug care, psychiatric care, psychological care, behavioral therapy, or therapeutic care that is:

- Prescribed for a person diagnosed with an autism spectrum disorder by a licensed physician or licensed psychologist; and

- Provided for a person diagnosed with an autism spectrum disorder by a licensed psychologist, licensed behavior analyst or other provider that is acting within the scope of his/her license.

Excludes coverage for reimbursement to an early intervention agency or school for services delivered through early intervention or school services.

Note: Capitalized terms in this Autism Spectrum Disorders section have the definitions assigned to them in NRS 689B.0335 and not necessarily the definitions in this MPD.

Blood Services for Surgery

Medically necessary blood and related supplies provided during a surgical or other procedure that requires blood replacement are covered services.

Chemotherapy

Chemotherapy and other drug therapies that are medically necessary to treat cancers and otherdiseases

and conditions are covered services. overed when ordered by a physician; chemotherapy must be pre-certified by the UM company.

See prescription benefits for orally administered chemotherapy drugs:

Patients undergoing chemotherapy may be eligible for 1 wig, any type, synthetic or not, per Plan Year (excluding sales tax).

Clinical Trials

The routine medical treatment costs, including all items and services that are otherwise generally available to Plan participants, received as part of a clinical trial or study, may be covered under NRS 695G.173. A clinical trial is the process for testing of new types of medical care that are in the final stages of research to find better ways to prevent, diagnose or treat diseases.

Diabetic Services for Type 1, Type 2, and Gestational Diabetes

Coverage is provided for the medically necessary management and treatment of diabetes, including infusion pumps and related supplies, medication, equipment, supplies, and appliances for the treatment of diabetes.

Coverage is provided for the medically necessary self-management of diabetes for training and education provided after you are diagnosed with diabetes for the care and management of diabetes, including, counseling in nutrition and the proper use of equipment and supplies for the treatment of diabetes.

Durable Medical Equipment (DME)

Coverage is provided for the purchase, rental, repair, or maintenance of durable medical equipment prescribed by a provider for a medically necessary condition other than kidney dialysis. **DME is limited to one purchase, repair, or replacement of a specific item of DME every 3 years.** Rental of DME to cover Medicare guidelines concerning rental to purchase criteria. The purchase or rental of DME more than $1,000 requires precertification from the UM company. Durable medical equipment is equipment that:

- Can withstand repeated use.
- Is not disposable.
- Is appropriate for use in the home.
- Is not useful in the absence of an illness or injury.
- Is prescribed by a physician.
- Meets CMS guidelines for coverage; and
- Is not primarily for convenience or comfort but serves a medical purpose.

Durable medical equipment includes, but is not limited to the following:

- Oxygen equipment (all oxygen and oxygen related equipment, except for oxygen while traveling on an airline).
- Wheelchairs.

- Hospital beds.
- Glucose monitors; and
- Warning or monitoring devices for infants (defined as a child 24-months old or less) suffering from recurrent apnea.

Coverage will be based on an amount equal to the generally accepted cost of durable medical equipment that provides the medically necessary level of care at the lowest cost.

Items not covered under this benefit include, but are not limited to: dressings, any equipment or supply to condition the air, appliances, ambulatory apparatus, arch supports, support stockings, corrective footwear, orthotics or other supportive devices for the feet, heating pads, personal hygiene, comfort, care, convenience or beautification items, deluxe equipment, and any other primarily non-medical equipment, except as otherwise covered and described within this *Schedule of Medical Benefits* and the *Benefit Limitations and Exclusions* sections.

Also excluded are exercising equipment, vibratory or negative gravity equipment, swimming or therapy pools, spas, and whirlpools (even if recommended by your medical provider to treat a medical condition).

Enteral Formulas and Special Food Products

Enteral Formulas and Special Food Products are covered in accordance with NRS 689B.0353.

Family Planning, Fertility, Infertility, Sexual Dysfunction Services and Male Contraception

Medical or surgical treatment for sexual dysfunction: There are some limits on sexual dysfunction drugs such as Viagra or Muse and are subject to the Plan Year Deductible. For more information, contact the pharmacy benefit manager

Coverage is provided for vasectomies and tubal ligations. Reversals of prior sterilization procedures, including, but not limited to tubal ligation and vasectomy reversals are excluded.

Medically necessary services for subscriber, spouse, and/or domestic partner to diagnose problems of infertility are covered for one workup per Plan Year up to three (3) evaluations per lifetime. For infertility services that are not covered under this Plan, see the *Benefit Limitations and Exclusions* section.

Bariatric/Weight Loss Surgery

Covered services include medically necessary surgical interventions to accomplish weight loss in individuals who are obese or morbidly obese *with* associated illnesses. These services may have a reduced benefit unless you receive precertification.

Bariatric weight loss surgery benefits, pre-and post-surgery, are available only when performed at an in-network Bariatric Surgery Center of Excellence facility, by an in-network surgeon and all ancillary providers. The third-party Claims Administrator will determine the in-network Bariatric Surgery Center of Excellence facility. It is the participant's responsibility to ensure that all

bariatric surgery services providers are in-network and facility chosen to provide services are in-network.

There is no payment if services are provided at an out-of-network facility or out-of-network surgeon, or other ancillary providers are used.

Participants are limited to one obesity related surgical procedure of any type in an individual's lifetime while covered under this Plan or any PEBP self-funded Plan. For example, a participant cannot have lap band surgery and subsequently seek benefits for gastric bypass. The first service related to surgical weight loss will be considered payable under this Plan, any others will not. If a participant had coverage under a different plan (any other plan other than a PEBP self-funded Plan) previously and subsequently had a bariatric surgery, they are still eligible to have one bariatric procedure paid for under the Plan, provided that all precertification criteria are met.

For lap band adjustments, the Plan will consider any adjustments made in the 12 months following surgery if the participant remains compliant with their post-surgical agreement as verified by the UM company. Any adjustments to the lap band after the first 12 months post-surgery will be subject to precertification.

It is the responsibility of the participant to ensure that their providers and facilities chosen to provide these services are in-network for benefits to be paid. Participants can verify the network status of any provider (including a facility) by calling the Claims Administrator located in the *Participant Contact Guide*.

Participants must receive treatment in a Bariatric Surgery Center of Excellence which has met the requirements outlined by the American College of Surgeons National Surgical Quality Improvement Program (ACS NSQIP) and is accredited by the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP). The accreditation of a Bariatric Surgery Center of Excellence helps identify providers with whom a participant should expect to receive safer and more effective surgical treatment. These MBSAQIP accredited providers adhere to a multidisciplinary surgical preparatory regimen to include but not limited to the following:

1. Behavior modification program supervised by a qualified professional.
2. Consultation with a dietician or nutritionist.
3. Documentation in the medical record of the participant's active participation and compliancewith the multidisciplinary surgical preparatory regimen at each visit. A physician's summary letter, without evidence of concurrent oversight is not sufficient documentation. Documentation should include medical records of the physician's initial assessment of the participant, and the physician's assessment of the participant at the completion of the multidisciplinary surgical preparatory regimen.
4. Exercise regimen (unless contraindicated) to improve pulmonary reserve prior to surgery, supervised by an exercise therapist or other qualified professional.
5. Program must have a substantial face-to-face component (must not be entirely

delivered remotely); and
6. Reduced-calorie diet program supervised by dietician or nutritionist.

If a participant has started any type of program to meet the pre-surgery criteria outlined below with an out-of-network provider (including a facility), those services will NOT be considered part of the Plan's mandatory precertification requirements. For the Plan to consider your bariatric surgery a covered benefit under this Plan; you will have to begin the precertification process again with the appropriate providers.

All services, pre- and post-surgery must be at an in-network facility, with in-network providers AND be at a certified Center of Excellence for bariatric weight loss.

Precertification/Pre-Surgery Criteria for Weight Loss Surgery
The participant or their physician must contact the UM company to begin the process toward surgical intervention for obesity. The initial contact will include:

- Notifying the participant that the precertification process begins with the initial contact to UM company.
- Notifying the participant that precertification requests presented to the UM company before the clinical criteria listed below has been completed will be denied. A precertificationrequest may be reconsidered upon completion of the clinical criteria.
- Informing the participant of the requirement to access and participate in a weight management and nutrition program.
- Documenting participant completion of the associated assessments required to be considered for the procedure.
- Educating the participant on how to access wellness/preventive services and how toproceed with meeting the clinical indications listed below; and
- Advising participants of Centers of Excellence in bariatric surgery provider in their geographic area.

Clinical Criteria for Weight Loss Surgeries is managed by the UM Company.

Surgical or invasive treatments for obesity or morbid obesity including but not limited to bariatric weight/loss services, reversals, and treatments to resolve complications are generally excluded, unless medically necessary and are covered as described above.

Travel Expenses:
This Plan provides reimbursement of certain costs associated with travel and hotel accommodations for the member and one additional person (spouse/domestic partner, family member or friend) when associated with bariatric/weight loss surgery and performed at a Center of Excellence that is located 50 or more miles from the member's residence. For travel expense benefits, refer to the Travel Expenses benefit section.

Expenses incurred for travel and hotel accommodations for bariatric/weight loss surgery not performed at a Center of Excellence are not covered.

Gender Dysphoria Related Services

This Plan provides certain benefits to individuals seeking medical services for the treatment of gender dysphoria.

All procedures, services, and supplies related to surgery and sex hormones associated with gender affirmation/confirmation should be reviewed by the UM Company for medical necessity.

The Plan limits a member ~~ages 18 and older~~ to one surgery type in an individual's lifetime while covered under any current or previous PEBP Plan.

Reversals of surgery to treat gender dysphoria will not be covered.

Genetic Counseling/Testing

Covered services include medically necessary genetic disease testing. Genetic disease testing is the analysis of human DNA, chromosomes, proteins, or other gene products to determine the presence of disease-related genotypes, phenotypes, karyotypes, or mutations for clinical purposes. Such purposes include those tests meeting criteria for the medically accepted standard of care for the prediction of disease risk, identification of carriers, monitoring, diagnosis, or prognosis within the confines of the statements in this definition. Coverage is not available for tests solely for research, or for the benefit of individuals not covered under the Plan.

Covered services also include the explanation by a genetic counselor of medical and scientific information about an inherited condition, birth defect, or other genome-related effects to an individual or family. Genetic counselors are trained to review family histories and medical records, discuss genetic conditions and how they are inherited, explain inheritance patterns, assess risk, and review testing options, where available.

Genetic testing may only be done after consultation with an appropriately certified genetic counselor and/or, in our discretion, as approved by a physician that we may designate to review the utilization, medical necessity, clinical appropriateness, and quality of such genetic testing. Medically necessary genetic counseling will be covered in connection with pregnancy management with respect to the following individuals:

- Expenses for genetic tests, except where otherwise noted in this document, including obtaining a specimen and laboratory analysis, to detect or evaluate chromosomal abnormalities, or genetically transmitted characteristics including:
- Pre-parental genetic testing intended to determine if a prospective parent or parents have chromosomal abnormalities that are likely to be transmitted to a child of that parent or parents; and
- Prenatal genetic testing intended to determine if a fetus has chromosomal abnormalities that indicate the presence of a genetic disease or disorder, except that

payment is made for fluid or tissue samples obtained through amniocentesis, non-invasive pre-natal testing for fetal aneuploidy, chorionic villus sampling (CVS), fetoscopy and alpha fetoprotein (AFP) analysis in pregnant women.
- Participants should contact the Plan's Claims Administrator to determine if proposed genetic testing is covered or excluded and the UM company for precertification requirements. See also the exclusions related to prophylactic surgery or treatment later in this section.

Genetic Counseling except as related to covered genetic testing as listed in the Genetic Testing and Counseling and the Preventive Covered services include genetic testing of heritable disorders as medically necessary when the following conditions are met:

- The results will directly impact clinical decision-making and/or clinical outcome for the individual.
- The testing method is considered scientifically valid for identification of a genetically linked heritable disease; and
- One of the following conditions is met:
    - The participant demonstrates signs/symptoms of a genetically linked heritable disease, or
    - The participant or fetus has a direct risk factor (e.g., based on family history or pedigree analysis) for the development of a genetically linked heritable disease.

Additional genetic testing/counseling will be covered in accordance with federal or state mandates.

In the absence of specific information regarding advances in the knowledge of mutation characteristics for a disorder, the current literature indicates that genetic tests for inherited disease need only be conducted once per lifetime of the member.

Routine panel screening for preconception genetic diseases, routine chorionic villous sampling, or amniocentesis panel screening testing, and pre-implantation embryonic testing will not be covered unless the testing is endorsed by the American College of Obstetrics and Gynecology or mandated by federal or state law.

Hearing Aids

Air conduction hearing aids are considered medically necessary when one or more of the following hearing loss criteria are met *in either or both ears*:

1. Hearing thresholds 40 dB HL or greater at <u>two or more</u> of these frequencies: 500, 1000, 2000, 3000, 4000 Hz; or
2. Hearing thresholds 26 dB HL or greater at <u>three</u> of these frequencies; or
3. For high frequency hearing loss, defined as loss occurring only above 2000 Hz:
    a. Hearing thresholds of 26 dB HL or greater at <u>three or more</u> of these frequencies: 2000, 3000, 4000, 6000 or 8000 Hz

4. Speech recognition less than 80 percent in either or both ears regardless of hearing threshold level.

Participants who meet the above hearing loss criteria: Each air conduction hearing aid is subject to a $50 copay (per device, per each ear), with maximum plan benefit of $1,500 per device every three (3) years.

Participants may submit a copy of their hearing aid payment receipt from the hearing aid provider to the third-party claims administrator to request reimbursement for the hearing aid benefit, less applicable copayment(s), and deductibles to receive credit towards the Out-of-Pocket Maximum.

Over the Counter hearing aids are excluded from the Plan.

Home Health Care

Medically necessary home health care is covered if such care is provided by an organization or professional licensed by the state to render home health services. Such care will not be available if it is substantially or primarily for the participant's convenience or the convenience of a caregiver. Home care is covered in the home only on a part-time and temporary basis and to the extent that such care is performed by a licensed or registered nurse or other appropriate therapist or provider acting within the scope of their license.

Home health care covered includes skilled nursing care, therapies, and other health related services provided in the home environment for other than convenience for patient or patient's family, personal assistance, or maintenance of activities of daily living or housekeeping. Covered home health care services under this part include home health care provided by a professional as the nature of the illness dictates.

Excluded from coverage as home health care are:

- Personal care, custodial care, domiciliary care, or homemaker services.
- In-home services provided by a licensed provider acting within the scope of their license.
  Over-the-counter medical equipment, over-the-counter supplies, or any prescription drugs, except to the extent that they are covered elsewhere in this *Schedule of Medical Benefits*.

Hospice Services

The following hospice care services are covered for members with a life expectancy of six months or 185 days or less as certified by his or her provider (limited to a lifetime benefit maximum of 185 days):

- Part-time intermittent home health care services totaling fewer than 8 hours per day and 35 or fewer hours per week

- Outpatient bereavement counseling of the participant and his or her immediate family (limited to 6 visits for all family members combined if they are not otherwise eligible for mental health benefits under their specific plan). Counseling must be provided by:
  - A psychiatrist.
  - A psychologist; or
  - A licensed, masters level clinician.
- Respite care providing nursing care for a maximum of 8 inpatient respite care days per Plan Year and 37 hours per Plan Year for outpatient respite care services. Inpatient respite care will be provided only when the UM company determines that home respite care is not appropriate or practical.

Hospital, Skilled Nursing Care, and Services in an Outpatient Surgical Center

Inpatient Care

Medically necessary inpatient hospital care is covered. Services include, but are not limited to:

- Services for medical conditions treated in an acute care hospital inpatient environment.
- Semi-private room and board (private room when medically necessary).
- General nursing care facilities, services, and supplies on an inpatient basis.
- Diagnostic services that are provided in a facility, whether such facility is a hospital or a freestanding facility. For related covered services refer to Other Services and Supplies in the *Schedule of Medical Benefits* section.
- Surgical and obstetrical procedures, including the services of a surgeon or specialist, assistant, and anesthetist or anesthesiologist together with preoperative and postoperative care.
- Maternity and newborn care for up to 48 hours of inpatient care for a mother and her newborn child following a vaginal delivery and up to 96 hours of inpatient care for a mother and her newborn child following a cesarean delivery. The time-periods will commence at the time of the delivery. Any decision to shorten the length of inpatient stay to less than those time-periods will be made by the attending physician after conferring with the mother.
  - Inpatient, short-term rehabilitative services, limited to treatment of conditions that are subject to significant clinical improvement over a continuous 30-day period from the date inpatient therapy commences in a distinct rehabilitation unit of a hospital, skilled nursing facility, or other facility approved by us (limited to 100 days per Plan Year).
- Inpatient alcohol and substance abuse rehabilitation services in a hospital, residential treatment facility, or day treatment program; and
- Inpatient mental health services.

Inpatient services to treat mental illness conditions are subject to medical necessity. Provider

visits received during a covered admission are also covered. Benefits are provided for medically necessary inpatient care, outpatient care, partial hospitalization, and provider office services for the diagnosis, crisis intervention and treatment of severe mental illness conditions and substance abuse conditions as noted in the *Schedule of Medical Benefits*.

Inpatient services must be provided by a licensed hospital, psychiatric hospital, alcoholism treatment center, or residential treatment center.

The member should contact the UM company to determine medical necessity, appropriate treatment levels and appropriate settings. Inpatient services are subject to precertification notification guidelines to avoid potential penalties related to non-notification of services.

If you are incapacitated and you (or a friend or relative) cannot notify the UM company within the above stated times in the UM section, above, the UM Company must receive notification as soon as reasonably possible after the admission or you may be subject to reduced benefits as provided in this Plan.

Medically necessary care at a skilled nursing facility (limited to 100 days per Plan Year) for non-custodial care is covered. A skilled nursing facility is a facility that is duly licensed by the state and/or federal government and that provides inpatient skilled nursing care, rehabilitation services, or other related health services that are not custodial or convenience in nature. Skilled nursing care includes medically necessary services that are considered by Medicare to be eligible for Medicare coverage as meeting a skilled need and that can only be performed by, or under the supervision of, a licensed or registered nurse. This Plan does not cover skilled nursing care that is not covered by CMS. Prior care in a hospital is not required before being eligible for coverage for care in a skilled nursing facility.

Outpatient Care

Medically necessary outpatient hospital or outpatient surgical center care is covered. Services furnished in a hospital's or outpatient surgical center premises are covered, including use of a bed and periodic monitoring by a hospital's nursing or other staff that are medically necessary to evaluate an outpatient's condition or determine the need for a possible admission to the hospital. If a hospital intends to keep a patient in observation status for more than 48 hours, observation status will become an inpatient admission for administration of benefits.

Coverage for the following benefits is dependent upon the benefits described in the *Schedule of Medical Benefits* for this Plan. Mental health and substance abuse outpatient services include, but are not limited to:

- Services for medical conditions treated in an acute care hospital outpatient environment.
- Semi-private room and board (private room when medically necessary) if patient is in observation status.

- General nursing care facilities, services, and supplies on an outpatient basis.
- Diagnostic services that are provided in a facility, whether such facility is a hospital or a freestanding facility.
- Surgical and obstetrical procedures, including the services of a surgeon or specialist, assistant, and anesthetist or anesthesiologist together with preoperative and postoperative care.
- Outpatient, short-term rehabilitative services.
- Outpatient alcohol and substance abuse rehabilitation services in a hospital, hospital residential treatment facility, or day treatment program; and
- Outpatient mental health services.

Medically necessary short-term outpatient habilitative and rehabilitative services are covered for:

- Short-term speech, physical, and occupational habilitative and rehabilitative therapy for acute conditions that are subject to significant clinical improvement over a 90-day period, as determined by the UM company from the date outpatient therapy commences or to maintain function in an individual. Precertification required for habilitative and rehabilitative therapy exceeding a combined visit limit of 90 visits per Plan Year: and
- Services for cardiac rehabilitation and pulmonary rehabilitation (limited to 60 visits/sessions per Plan Year for each type of therapy).

Medically necessary services such as radiation therapy and chemotherapy (including chemotherapy drugs), are covered to the extent that such services are delivered in the most appropriate clinical manner and setting as part of a treatment plan.

Services that are not covered under this benefit include:

- Any services or supplies furnished in an institution that is primarily a place of rest, a place for the aged, a custodial facility, or any similar institution.
- Private duty nursing and private rooms in an inpatient setting.
- Personal, beautification, or comfort items for use while in a hospital or skilled nursing facility; and
- Services related to psychosocial rehabilitation or care received as a custodial inpatient.

No Surprises Act

The federal No Surprises Act protects patients who receive emergency services at a hospital, at an independent freestanding emergency department and from air ambulances. In addition, the law protects patients who receive emergency services from a Non-PPO provider at an in-network facility. Beneficiaries receiving these services will only be responsible for paying their in-network cost sharing and cannot be balance billed by the provider or facility for emergency services.

Emergency Services

Emergency Services are covered:

- Without the need for a prior authorization determination, even if the services are provided out-of-network;
- Without regard to whether the health care provider furnishing the Emergency Services is a PPO provider or a PPO emergency facility, as applicable, with respect to the services;
- Without imposing any administrative requirement or limitation on out-of-network Emergency Services that is more restrictive than the requirements or limitations that apply to Emergency Services received from PPO providers and PPO emergency facilities;
- Without imposing cost-sharing requirements on out-of-network Emergency Services that are greater than the requirements that would apply if the services were provided by a PPO provider or a PPO emergency facility;
- By calculating the cost-sharing requirement for out-of-network Emergency Services as if the total amount that would have been charged for the services were equal to the Recognized Amount for the services; and
- By counting any cost-sharing payments made by the participant or beneficiary with respect to the Emergency Services toward any in-network deductible or in-network out-of-pocket maximums applied under the plan (and the in-network deductible and in-network out-of-pocket maximums are applied) in the same manner as if the cost-sharing payments were made with respect to Emergency Services furnished by a PPO provider or a PPO emergency facility.

Your cost sharing amount for Emergency Services from Non-PPO Providers will be based on the lessor of billed charges from the provider or the Qualified Payment Amount (QPA).

*see also **NRS** 695G.170 for medically necessary emergency services at any hospital in Nevada. Post Stabilization Services
Emergency Services furnished by a Non-PPO Provider or Non-PPO emergency facility (regardless of the department of the hospital in which such items or services are furnished also includes post stabilization services (services after the patient is stabilized) and as part of outpatient observation or an inpatient or outpatient stay related to the emergency medical condition, until:

- The provider or facility determines that the participant or beneficiary is able to travel using nonmedical transportation or nonemergency medical transportation; and
- The participant or beneficiary is supplied with a written notice, as required by federal law, that the provider is a Non-PPO provider with respect to the Plan, of the estimated charges for your treatment and any advance limitations that the Plan may put on your treatment, of the names of any PPO providers at the facility who are able to treat you, and that you may elect to be referred to one of the participating providers listed; and
- The participant or beneficiary gives informed consent to continued treatment by the nonparticipating provider, acknowledging that the participant or beneficiary

understands that continued treatment by the nonparticipating provider may result in greater cost to the participant or beneficiary.

Non-Emergency Items or Services from a Non-PPO Provider at a PPO Facility

With regard to non-emergency items or services that are otherwise covered by the Plan, if the covered non-emergency items or services are performed by a Non-PPO provider at a PPO facility, the items or services are covered by the plan:

- With a cost-sharing requirement that is no greater than the cost-sharing requirement that would apply if the items or services had been furnished by a PPO provider,
- By calculating the cost-sharing requirements as if the total amount that would have been charged for the items and services by such Non-PPO provider were equal to the Recognized Amount for the items and services.
- By counting any cost-sharing payments made by the participant or beneficiary toward any in-network deductible and in-network out-of-pocket maximums applied under the plan (and the in-network deductible and out-of-pocket maximums must be applied) in the same manner as if such cost-sharing payments were made with respect to items and services furnished by a PPO provider,
- Non-emergency items or services performed by a Non-PPO provider at a PPO facility will be covered based your out-of-network coverage if:

  - At least 72 hours before the day of the appointment (or three (3) hours in advance of services rendered in the case of a same-day appointment), the participant or dependent is supplied with a written notice, as required by federal law, that the provider is a Non-PPO provider with respect to the Plan, of the estimated charges for your treatment and any advance limitations that the Plan may put on your treatment, of the names of any PPO providers at the facility who are able to treat you, and that you may elect to be referred to one of the PPO providers listed; and
  - The participant or dependent gives informed consent to continued treatment by the Non-PPO provider, acknowledging that the participant or beneficiary understands that continued treatment by the Non-PPO provider may result in greater cost to the participant or beneficiary.

- The notice and consent exception does not apply to Ancillary services and items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished, regardless of whether the Non-PPO provider satisfied the notice and consent criteria, and therefore these services will be covered:

  - With a cost-sharing requirement that is no greater than the cost-sharing requirement that would apply if the items or services had been furnished by a PPO provider,
  - With cost-sharing requirements calculated as if the total amount charged for the items and services were equal to the Recognized Amount for the items and services, and

- With cost-sharing counted toward any in-network deductible and in-network out of pocket maximums, as if such cost-sharing payments were with respect to items and services furnished by a PPO provider.

Your cost sharing amount for Non-emergency Services at PPO Facilities by Non-PPO Providers will be based on the lessor of billed charges from the provider or the Qualifying Payment Amount.

Air Ambulance Services

If you receive Air Ambulance services that are otherwise covered by the Plan from a non-PPO provider, those services will be covered by the Plan as follows:

- The Air Ambulance services received from a Non-PPO provider will be covered with a cost-sharing requirement that is no greater than the cost-sharing requirement that would apply if the services had been furnished by a PPO provider.
- In general, you cannot be balance billed for these items or services. Your cost-sharing will be calculated as if the total amount that would have been charged for the services by a PPO provider of Air Ambulance services were equal to the lesser of the Qualifying Payment Amount or the billed amount for the services.
- Any cost-sharing payments you make with respect to covered Air Ambulance services will count toward your Network (PPO) deductible and Network (PPO) out-of-pocket maximum in the same manner as those received from a PPO provider.

Payments to non-PPO Providers and Facilities

The Plan will make an initial payment or notice of denial of payment for Emergency Services. Non-Emergency Services at PPO Facilities by Non-PPO Providers, and Air Ambulance Services within 30 calendar days of receiving a clean claim from the Non-PPO provider. The 30-day calendar period begins on the date the plan receives the information necessary to decide a claim for payment for the services.

If a claim is subject to the No Surprises Act, the participant cannot be required to pay more than the cost-sharing under the Plan, and the provider or facility is prohibited from billing the participant or dependent in excess of the required cost-sharing.

The Plan will pay a total plan payment directly to the non-PPO provider that is equal to the amount by which the Out-of-Network Rate for the services exceeds the cost-sharing amount for the services, less any initial payment amount.

External Review

An Adverse Benefit Determination that is related to an Emergency Service, Non-Emergency Service provided by a non-PPO provider at a PPO facility, and/or Air Ambulances services, as covered under the federal No Surprises Act, is eligible for External Review. Please see the External Review procedures in the SPD for further information.

Continuity of Coverage

If you are a Continuing Care Patient, and the contract with your Network provider or facility terminates, or your benefits under a group health plan are terminated because of a change in terms of the providers' and/or facilities' participation in the plan:

1. You will be notified in a timely manner of the contract termination and of your and of your right to elect continued transitional care from the provider or facility; and
2. You will be allowed up to ninety (90) days of continued coverage at Network cost sharing to allow for a transition of care to a Network provider.

This plan adheres to Covered for continued medical treatment ascribed under NRS 695G.164

Incorrect PPO Provider Information

A list of PPO providers is available to you without charge by visiting the website or by calling the phone number on your ID card. The network consists of providers, including hospitals, of varied specialties as well as general practice, who are contracted with the Plan or an organization contracting on its behalf.

If you obtain and rely upon incorrect information about whether a provider is a PPO provider from the Plan or its administrators, the Plan will apply PPO cost-sharing to your claim, even if the provider was Non-PPO.

Lab and Diagnostic Services

Coverage is provided for medically necessary laboratory and diagnostic procedures, services, and materials, including:

- Diagnostic x-rays.
- Fluoroscopy.
- Electrocardiograms; and
- Laboratory tests.

Coverage is also provided for other laboratory and diagnostic screenings as well as physician services related to interpreting such tests.

Outpatient laboratory services are covered for pre-admission testing, urgent care, or emergency room. Pre-admission testing must be performed within 7 days of a scheduled hospital admission or outpatient surgery. The testing must be related to the sickness or injury for which admission or surgery is planned.

Outpatient laboratory services for routine/preventive lab testing must be performed at a non-hospital-based, freestanding laboratory such as Lab Corp or Quest.

If a freestanding, non-hospital-based laboratory facility is not available within 50 miles of your residence, you may use an in-network outpatient hospital facility or hospital-based lab draw

station.

Routine lab services from independent labs may not be paid as wellness unless the TPA system finds a corresponding wellness office visit within a reasonable number of days prior or after lab date to validate wellness diagnosis.

Mastectomy and Reconstructive Surgery

Breast reconstructive surgery and the internal or external prosthetic devices are covered for members who have undergone mastectomies or other treatments for breast cancer. Treatment will be provided in a manner determined in consultation with the physician and the member. Subject to all the terms and conditions of this *Schedule of Medical Benefits*, if a covered mastectomy or other breast cancer treatment is performed, we will also provide coverage for:

All stages of reconstruction of the breast on which the mastectomy has been performed.

- Surgery and reconstruction of the other breast to produce a symmetrical structure.
- Prostheses; and
- Physical complications for all stages of mastectomy, including lymphedemas.

If reconstructive surgery occurs within three years after a mastectomy, the amount of the benefits for that surgery will equal the amounts provided for in the Plan at the time of the mastectomy. If the surgery occurs more than three years after the mastectomy, the benefits provided are subject to all the terms, conditions, and exclusions contained in the Plan at the time of reconstructive surgery.

This Plan complies with the Women's Health and Cancer Rights Act of 1998 (WHCRA) Breast reconstructive surgery and the internal or external prosthetic devices are covered for members who have undergone mastectomies or other treatments for breast cancer. Treatment will be provided in a manner determined in consultation with the physician and the member. For any covered individual who is receiving mastectomy-related benefits, coverage will be provided for:

- All stages of reconstruction of the breast on which the mastectomy has been performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- External prostheses (breast forms that fit into your bra) that are need before or during reconstruction; and Treatment of physical complications of all stages of the mastectomy, including lymphedema (fluid build-up in the arm and chest on the side of the surgery).

Treatment of leaking breast implant is covered when the breast implant surgery was performed for reconstructive services following a partial or complete mastectomy as mandated by the Women's Health and Cancer Rights Act.

Participants should use the Plan's precertification procedure to determine if a proposed surgery

or service will be considered cosmetic surgery or medically necessary reconstructive services.

Medical Care

Medically necessary medical care and services, performed by a physician or other professional on an inpatient and outpatient basis, are covered, including:

- Office visits and consultations.
- Hospital and skilled nursing facility services.
- Ambulatory surgical center services.
- Home health care services.
- Surgery; and
- Other professional services.

Note: The Plan Administrator or its designee will determine if multiple surgical or other medical procedures will be covered as separate procedures or as a single procedure based on the factors in the Surgery/Surgeries definition in the *Key Terms and Definitions* section.

Assistant surgeon fees will be reimbursed for medically necessary services to a maximum of 20% of the eligible expenses payable to the primary surgeon. See Certified Surgical Assistant in the *Key Terms and Definitions* section.

Mental Health Services

Medically necessary mental health services provided by a doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other qualified mental health care professional are covered according to the limits provided in the *Schedule of Medical Benefits* sections.

All outpatient partial hospitalization programs, partial residential treatment programs, and inpatient services for mental health require precertification. This Plan provides all mental health and substance abuse benefits in accordance with the *Mental Health Parity and Addition Equity Act of 2008.*

Maternity and Newborn Services

Medically necessary maternity services for pregnant participants are covered, including prenatal and postpartum care, related delivery room and ancillary services and newborn care. Newborn care includes care and treatment of medically diagnosed congenital defects, birth abnormalities, or prematurity, and transportation costs of newborn to and from the nearest facility staffed and equipped to treat the newborn's condition. Newborn care is subject to the eligibility requirements as defined in the Schedule of Medical Benefits.

Notwithstanding anything in this Schedule of Medical Benefits to the contrary, participant does not need precertification from the UM company to obtain access to obstetrical or gynecological care from a professional in this Plan's network who specializes in obstetrics or gynecology. The provider, however, may be required to comply with certain procedures, including obtaining

precertification for certain services, following a preapproved treatment plan, or procedures for making referrals. For a list of participating providers who specialize in obstetrics or gynecology, refer to the EPO Plan network at *www.pebp.state.nv.us*.

Notwithstanding anything in this *Schedule of Medical Benefits* to the contrary, in the case of a person who has a child enrolled in coverage, this Plan will permit such person to designate any pediatrician as a primary care physician if such pediatrician is a participating provider.

When the member has Employee-Only coverage, the newborn will be covered under the member's plan for the first 31 days (NRS 689B.033). Individual deductible, copay, coinsurance, and out of pocket limitations, where applicable, will apply during the initial coverage period.

Services that are not covered include:

- Amniocentesis to the extent that it is performed to determine the sex of the child.
- Non-newborn circumcisions after eight weeks of age unless medically necessary and provided a precertification.

Obesity Care Management Program

The Obesity Care Management (OCM) Program is open to participants who have been diagnosed as obese by their physician and who meet the criteria set out in this section.

Participants who opt-in to the OCM Program may be eligible for enhanced benefits. These benefits include:

- Services provided by an in-network provider certified by the American Board of Bariatric Medicine (ABBM) and specializes in weight loss services or if there is no certified provider within 50 miles of a participant's residence, services may be provided by any in-network provider.
- Laboratory tests provided by an in-network free-standing, non-hospital-based outpatient laboratory facility such as Lab Corp or Quest.
- Nutritional counseling services when provided in-network, frequency is determined by the Claims Administrator and is based on medical necessity.
- Meal replacement therapy benefit for individuals who are diagnosed as morbidly obese only. Morbid obesity means that a person is more than 100 pounds over normal weight or has a BMI of 40 or higher. This must be confirmed by your weight loss medical provider.

Weight Loss Medications:

- The Plan covers certain only short-term use obesity/weight loss generic medications as identified by the Plan's Pharmacy Benefits Manager. Contact the Pharmacy Benefit Manager or refer to the Plan's prescription drug formulary to determine what weight loss medications are covered by the enhanced benefit. Long-term weight loss medications are excluded.

- Copayments for Tier 1 (Generic) drugs apply to the Out-of-Pocket Maximum. Copayment for a 31-90-day supply is subject to three times the listed 30-day retail copayment.
- This Plan does not coordinate prescription drug plan benefits.

Medications purchased at non-participating pharmacies are not covered under this Plan.
Gym memberships, exercise equipment and bariatric restrictive weight loss surgery is not included in the OCM benefits. Refer to the *Summary of Medical Benefits* section for more information.

For enrollment information, please contact the Claims Administrator as listed in this document under the *Participant Contact Guide*. When you enroll in the program, your effective date will typically be the 1st of the month following your enrollment in the program. The effective date will be determined by PEBP.

The information described in this section provides a summary of the Program's functions. For more detailed information, please contact the Claims Administrator.

The Obesity Care Management Program is optional and considered an "opt-in" Program. To be eligible for the enhanced wellness benefits, participants must meet certain criteria and adhere to certain participation requirements.

Once you have met your final weight loss goal as determined by your weight loss provider at the onset of your participation in a medically supervised weight loss program, benefits under the Obesity Care Management Program will end. This Plan does not provide benefits for ongoing maintenance care. If you choose to receive ongoing maintenance care, you will be responsible for the cost of receiving the services.

The Claims Administrator provides an Obesity Care Management Participant Program navigation guide available through the PEBP Member Portal, see the *Participant Contact Guide* for more information.

The Obesity Care Management Program is administrated by the Claims Administrator.

Engagement in the Program
You must remain actively engaged in a medically supervised weight loss program.

Monitoring Engagement
The Claims Administrator will assist your weight loss provider with completing monthly progress reports. The initial report should include your weight and BMI or waist circumferences, and a description of your treatment plan to include weekly weight loss goals, final weight loss goal, exercise regimen, diet, and nutrition instructions. Subsequent monthly reports should provide information regarding your weight loss progress and adherence to the treatment plan. Submission of these reports will be a requirement for payment under the enhanced wellness

benefits. If your monthly weight loss reports are not received by the Claims Administrator, your benefits under this program will end, and your coverage will return to the standard EPO Plan benefits where other Plan limitations will apply. The effective date of the return to the standard EPO Plan benefits will be the first day of the month following the non-compliance notification received from the Claims Administrator.

How to Enroll in the Obesity Care Management Program

1. Contact the Claims Administrator for a list of in-network weight loss providers. This information is located on the Claims Administrator's website by logging into the E-PEBP Portal.
2. Make an appointment with an in-network weight loss provider. The Claims Administrator can also help you identify which in-network provider may best meet your needs, based on geography or other specialized needs you may have.
3. When you make an appointment with your in-network weight loss provider, before you go, be sure to take an Obesity Care Management Program Enrollment form with you. This form is located on the Claims Administrator's website under forms.
4. Have your in-network weight loss provider complete the enrollment form and submit (by mail or fax) the completed form to the Claims Administrator. Their name, address and fax number are provided on the enrollment form.
5. The Claims Administrator will review the information submitted by your provider and if the information indicates that you meet the criteria for the weight loss program benefits, the Claims Administrator will enroll you in the program. The Claims Administrator will notify PEBP and the Pharmacy Benefit Manager of your enrollment. If you do not meet the criteria for weight loss benefits, the Claims Administrator will notify you of the denial of benefits.
6. Engagement in the Program.

Benefits under the Obesity Care Management Program

The following benefits are included, many at no cost to you, when provided under this program subject to the limits in the *Summary of Medical Benefits* section:

- Office Visits.
- Laboratory tests.
- Nutritional counseling.
- Meal replacement therapy; and
- Certain medications under the prescription drug component of the Plan.

Oral Surgery, Dental Services, and Temporomandibular Joint Disorder

Medically necessary oral surgery procedures are covered (inpatient or outpatient) related to the following:

- Accidental injury to the jaw bones or surrounding tissues when the injury occurs, and the repair. Services must commence within 90 days after the accidental Injury, regardless of date enrolled in the Plan. *Services that commence after 90 days are not covered, unless determined to be medically appropriate*.
- Treatment for tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, and roof and floor of the mouth.
- Non-dental surgical procedures and hospitalization required for newly born and children placed for adoption or newly adopted to treat congenital defects, such as cleft lip and cleft palate.
- Repair and restoration of teeth from injuries that arise from non-gustatory trauma.
- Extraction of teeth when related to radiation therapy or in advance of an organ transplant (other than a corneal transplant).
- Medical or surgical procedures occurring within or adjacent to the oral cavity or sinuses including treatment of fractures.
- Under certain circumstances (listed below) the medical Plan will pay for the facility fees and anesthesia associated with medically necessary dental services if the utilization review company determines that hospitalization is medically necessary to safeguard the health of the patient during performance of dental services:
    - Dental general anesthesia for a beneficiary when services are rendered in a hospital or outpatient surgical facility, when enrolled individual is being referred because, in the opinion of the dentist, the individual:
        - Is under age 18 and has a physical, mental, or medically compromising condition; or
        - Is under age 18 and has dental needs for which local anesthesia is ineffective because of an acute infection, an anatomic anomaly, or an allergy; or
        - Patient has a documented mental or physical impairment requiring general anesthesia for the safety of the patient.
        - Is under age seven (7) and diagnosed with extensive dental decay substantiated by x-rays and narrative reporting provided by the dentist.
        - No payment is extended toward the dentist or the assistant dental provider under this Plan. Refer to the dental benefits described in the PEBP Self-funded PPO Dental Plan Master Plan Document available at *www.pebp.state.nv.us*.

Temporomandibular Joint Disorder (TMJ) and dysfunction services and supplies including night guards are covered only when the required services are not recognized dental procedures. TMJ surgeries are covered under the medical benefits based on medical necessity and are limited to an annual maximum of one surgery and a lifetime maximum of two (2) surgeries.

Precertification is required for dental general anesthesia in a hospital or outpatient surgical facility. Dental anesthesiology services are covered only for procedures performed by a qualified

specialist in pediatric dentistry, a dentist educationally qualified in a recognized dental specialty for which hospital privileges are granted or who is certified by completion of an accredited program of post-graduate hospital training to be granted hospital privileges.

Only the services and supplies described above are covered, even if the condition is due to a genetic, congenital, or acquired characteristic. Exclusions include:

- Except as described above as an inclusion, services involving treatment to the teeth; extraction of teeth; repair of injured teeth; general dental services; treatment of dental abscesses or granulomas; treatment of gingival tissues (other than for tumors); dental examinations; restoration of the mouth, teeth, or jaws because of injuries from biting, chewing, or accidents; artificial implanted devices; braces; periodontal care or surgery; teeth prosthetics and bone grafts regardless of etiology of the disease process; and repairs and restorations except for appliances that are medically necessary to stabilize or repair teeth after an injury as set forth above;
- Dental and or medical care including mandibular or maxillary surgery, orthodontia treatment, oral surgery, pre-prosthetic surgery, any procedure involving osteotomy to the jaw, and any other dental product or service except as set forth above.
- Treatment to the gums and treatment of pain or infection known or thought to be due to dental or medical cause and near the teeth or jaw, braces, bridges, dental plates or other dental orthosis or prosthesis, including the replacement of metal dental fillings; and
- Other supplies and services including but not limited to cosmetic restorations, veneers, implants, cosmetic replacements of serviceable restorations, and materials (such as precious metals).

Orthopedic Devices and Prosthetic Devices

Coverage for orthopedic devices is limited to medically necessary braces for problems requiring complete immobilization or for support, or if the braces are custom fitted or have rigid bar or flat steel supports and stays, splints, devices for congenital disorders, post, and pre-operative devices.

One medically necessary prosthetic device, approved by the Centers for Medicare & Medicaid Services (CMS), is covered for each missing or non-functioning body part or organ every three years. Coverage is limited to:

- Devices that are required to substitute for the missing or non-functioning body part or organ.
- Adjustment of initial prosthetic device; and
- The first pair of eyeglasses or contact lenses (up to the Medicare allowable) immediately following cataract surgery.
- Repair and replacement of prosthetic devices is not covered except in limited situations involving mastectomy reconstructive surgery.

Orthopedic shoes, foot orthotics or other supportive devices of the feet are excluded, except when such devices are:

- An integral part of a covered leg brace and its expense is included as part of the cost of the brace:
- For diabetes mellitus and for foot deformity, history of pre-ulcerative calluses, history of previous ulceration, peripheral neuropathy with evidence of callus formation, poor circulation or previous amputation of the foot or part of the foot:
- For rehabilitation prescribed as part of post-surgical or post-traumatic casting care; or
- Prosthetic shoes for members with a partial foot.

Ostomy Care Supplies

Coverage is provided for medically necessary care and supplies after colon, ileum, or bladder surgery to assist in carrying on normal activities with a minimum of inconvenience.

Partial Hospitalization Services

Partial hospitalization services are covered for mental illness and substance abuse according to the benefits listed in the *Schedule of Medical Benefits*. The same services covered for inpatient services are also covered for partial hospitalization. One inpatient day is defined as an admission to a facility for more than 12 hours of treatment. One partial treatment day is defined as no less than three and no more than 12 hours of therapy per day. Partial day treatment is covered only when the member receives care through a day treatment program.

Podiatry Services

Podiatry services are covered for the medically necessary treatment of acute conditions of the foot such as infections, inflammation, or injury and other foot care that is disease related.

The following services are not covered:

- Non-symptomatic foot care such as the removal of warts (except plantar warts); corns or calluses; and including but not limited to podiatry treatment of bunions, toenails, flat feet, fallen arches, and chronic foot strain; and routine foot care.

Preventive Services

Notwithstanding anything to the contrary in this *Summary of Medical Benefits*, the following preventive services will be covered without any participant cost-sharing if such services are provided by a participating provider:

- Periodic physical examinations and routine immunizations.
- Routine gynecologic examination (one per Plan Year), including annual cytologic screening test (Pap smear) for women 18 years of age or older, pelvic examination, urinalysis, and breast examination.

- Screening mammograms every 1-2 years for women 40 years of age or older regardless of diagnosis, or beginning at age 35 for members with a high-risk of breast cancer.
- Well-baby care, including immunizations in accordance with the American Academy of Pediatrics.
- Colorectal cancer screening starting at age 45 years in accordance with:
    - The guidelines published by the American Cancer Society; or
    - Other guidelines or reports concerning such screening that are published by nationally recognized professional organizations and that include current or prevailing supporting scientific data.
- Immunizations, including COVID-19, influenza, pneumococcal, Haemophilus influenza B, hepatitis A, hepatitis B, hepatitis C, rubella, measles, diphtheria, human papillomavirus (HPV), pertussis (whooping cough), poliovirus, rotavirus, varicella (chickenpox), shingles (herpes zoster) and tetanus, if such immunizations have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved (Note: Immunizations related to foreign travel or employment are excluded.);
- Hearing and vision screening for children through age 17 to determine the need for hearing and vision correction.
- Evidence-based items or services that have an "A" or "B" Recommendation by the United States Preventive Services Task Force (USPSTF) and Section 2713(a)(5) of the Public Health Service Act and Section 9(h)(v) (229) of the 2015 Consolidated Appropriations Act.
- With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration of the U.S. Department of Health and Human Services guidelines including the American Academy of Pediatrics Bright Futures guidelines; and
- With respect to women, such additional preventive care and screenings not described under this section as provided for in comprehensive guidelines supported by the Health Resources and Services Administration of the U.S. Department of Health and Human Services.
- Human Papillomavirus testing and vaccination under NRS 695G.171.

Women's Contraceptives

This Plan covers all FDA approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity. The FDA requires the services to be "prescribed" by a physician even for over-the-counter methods. This Plan also adheres to NRS 695G.1715.

Colorectal Cancer Screening

Colorectal screening tests are covered at 100% when provided in-network for adults aged 45

years and older who are at average risk of colorectal cancer in accordance with the American Cancer Society's qualified recommendations; or beginning at age 40 for members with a high-risk of colorectal cancer. For more information regarding colorectal screening guidelines, contact the Claim's Administrator.

Screening Mammograms (2-D or 3-D)

Preventative 2-D or 3-D mammograms are covered at 100% for women age 40 years and older, under the Affordable Care Act and USPSTF , or beginning at age 35 for members with a high-risk of breast cancer, when performed in-network.

Healthy Diet and Physical Activity for Cardiovascular Disease Prevention in Adults With Cardiovascular Risk Factors: Behavioral Counseling Interventions

Healthy Diet/Physical Activity Counseling and Obesity Screening/Counseling for adults aged 18 years and older are covered under the Wellness/Preventive Care Benefit when the Participant or covered dependent is referred by a primary care practitioner; for those who have a basal metabolic index (BMI) of 30 or greater; and have additional cardiovascular disease (CVD) risk factors. This wellness/preventive benefit is limited to twelve (12) Health Diet/Physical Activity Counseling or Obesity Screening/Counseling sessions per Plan year according to recommendations from the USPSTF.

Smoking/Tobacco Cessation

- Prescription and over-the-counter smoking/tobacco cessation products are covered under the prescription drug program. Over-the-counter smoking cessation products must be accompanied by a prescription written by a physician.
  - Some examples of cessation products eligible to be paid at 100% include Chantix (by prescription only), nicotine gum, nicotine patches, and nicotine lozenges.

  Some limitations on quantity may apply and are at the discretion of the Pharmacy Benefit Manager and your physician.
- Benefits for over-the-counter products are limited to those that are FDA approved and recommendations by the Surgeon General.
- Over-the-counter smoking/tobacco cessation products may be obtained by presenting your physician's written prescription to an In-Network pharmacy, or you can submit your purchase receipt for the product with your physician's written prescription attached to the Prescription Drug Reimbursement Claim Form (this form is located at www.pebp.state.nv.us).
- Second-line therapies such as clonidine hydrochloride and nortriptyline hydrochloride are sometimes used in the management of smoking/tobacco-cessation; however, due to the lack of an FDA-approved indication for smoking cessation, as well as undesirable side effect profiles, currently prohibit these agents from achieving first-line classification and therefore, not covered under the *Preventive Care/Wellness Services* Benefit.
- The Plan does not cover electronic cigarettes.

For more information, please visit:

Preventive Services for Adults and Families*: Visit the U.S. Preventive Task Force at https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-and-b-recommendations*

Preventive Services for Women, Including Pregnant Women: *Visit Human Resources & Services Administration (HRSA) at https://www.hrsa.gov/womens-guidelines/index.html*

Vaccines for infants, children, and teens: *Visit the U.S. Department of Health & Human Services at https://www.hhs.gov/vaccines/index.html*

Vaccines & Immunizations: *Visit the Centers for Disease Control and Prevention at https://www.cdc.gov/vaccines/index.html*

Preventive Health Services: *Visit HealthCare.gov at https://www.healthcare.gov/coverage/preventive-care-benefits/*

Preventive care services identified through the above links is recommended services. It is up to the participant and their physician or provider of care to determine which services to provide. The Plan Administrator has the authority to determine which services and quantity limits will be covered at the 100% wellness benefit; unless otherwise mandated by the Affordable Care Act or mandated in accordance with applicable Nevada Revised Statutes.

Note: This Plan complies with NRS 695G as related to contraceptive methods, utilization management, step therapy, prior authorization, categorization of prescription drugs (meaning Preferred Generic, Preferred Brand and Non-Preferred Brands), and cost-sharing. For more information, refer to https://www.leg.state.nv.us/nrs/nrs-695g.html.

Radiation Therapy

The Plan covers medically necessary specialty radiology when ordered by a physician or health care practitioner acting with the scope of their license, including, but not limited to, MRI, MRA, MRS MRT, PET, SPEC, and CT scan. See the *Utilization Management* (Prior Authorization) section for precertification requirements.
The Plan covers technical and professional fees associated with:

- diagnostic and curative services, including radiation therapy, and
- pre-admission testing: Outpatient radiology tests performed 7 days prior to a scheduled hospital admission or outpatient surgery. The testing must be related to the sickness or injury for which admission or surgery is planned.

Real Appeal

Nevada Public Employees' Benefits Program has partnered with UMR's Real Appeal program. Real Appeal provides eligible members a benefit for virtual weight loss and weight management coaching sessions. Sessions are covered under the preventive care benefit resulting in no cost-share to members. Real Appeal supports members eighteen (18) years of age and older.

This support includes, but not limited to, one-on-one coaching and online group sessions with

supporting video content delivered by a virtual coach.

A qualified enrolled member will receive:

- Access to a coaches who will guide you through the program and develop a custom plan that fits your needs, preferences, and goals.
- 24/7 access to digital tools and dashboards.
- A Real Appeal kit containing health weight management tools that may include fitness guides, recipes, digital food and weight scales
- Support from online group classes with a coach and other members who share what's helped them achieve success.

For more information, contact the Plan's third-party claims administrator listed in the Participant Contact Guide.

Rehabilitative and Habilitative Therapy

Coverage is provided for medically necessary physical, speech, occupational, cardiac, and pulmonary therapy habilitative and rehabilitation services that are performed by a physician or by a therapy provider licensed in accordance with state regulations for that therapy discipline. Coverage for these services is available for acute conditions arising from illness or injury, as well as chronic or developmental conditions up to the benefit limits as defined in the benefit Plan.

- Prior authorization for outpatient rehabilitative and habilitative therapy (occupational, physical, or speech) exceeding 90 combined visits per Plan Year (limit not applied to therapy treating a behavioral health condition).
- There is no limit for Cardiac Rehabilitation services.

Skin Lesions

Coverage is provided for medically necessary removal of skin lesions and related pathological analysis of such lesions. Coverage is provided for the removal of port wine lesions.

Chiropractic Services Spinal Manipulation (non-surgical)

Coverage is provided for up to 20 visits per Plan Year for medically necessary spinal manipulations and adjustments.

Maintenance services are not a covered benefit.

Transplant Services

Medically necessary organ transplants at an approved Center of Excellence are covered when you are the organ recipient in the following cases:

- Bone marrow.
- Cornea.
- Heart.

- Heart and lung.
- Intestinal and liver.
- Kidney.
- Liver.
- Lung.
- Pancreas.
- Pancreas and kidney; and
- Stem cell.

Centers of Excellence are facilities that meet vigorous credentialing requirements for the specific type of organ transplant. A facility that is designated as a Center of Excellence for one type of organ transplant may not be designated as a Center of Excellence for another type of organ transplant. Designation as a Center of Excellence is at the UM company's sole discretion.

Organ transplants are only covered where the organ donor's suitability meets the OPTN/UNOS (Organ Procurement and Transplantation Network/United Network for Organ Sharing) donor evaluation and guideline criteria, when applicable.

Coverage for related transplant services is limited to:

- Tests necessary to identify an organ donor.
- The reasonable expense of acquiring the donor organ.
- Transportation of the donor organ (but not the donor), and life support where such support is for the sole purpose of removing the donor organ.
- Storage costs of an organ, but only as part of an authorized treatment protocol; and
- Follow-up care.

The following services are excluded from coverage:

- Services provided at a facility that has not been designated as an approved Center of Excellence.
- Services provided to an organ donor unless otherwise specified elsewhere in this document.
- Services provided in connection with purchasing or selling organs.
- Transplants utilizing any animal organs.
- Any transportation of the donor (as opposed to transportation of the donor organ only) is excluded, except as otherwise covered under the *Travel Expense* section for transplant services.
- Any expenses associated with an organ transplant where an alternative remedy is available are excluded.
- Artificial heart implantation is excluded.
- Services for which government funding or other insurance coverage is available are excluded.

- Tissue transplants (whether natural or artificial replacement materials or devices are used) or oral implants, including the treatment for complications arising from tissue or organ transplants or replacement are excluded, except as described above.

2nd.MD Opinion

2nd.MD provides eligible members with direct access to elite specialists across the county for expert second opinions. Specialists answer questions about disease, cancer, chronic conditions, surgery or procedure, medications, and treatment plans. All specialists are board certified, leaders in research, and pioneers in medicine. To learn more visit *www.2nd.MD/PEBP* or call 1-866-841-2575.

Telemedicine or Telehealth (Doctor on Demand)

Telemedicine (virtual medicine) is available through Doctor on Demand, PEBPs contracted telehealth provider and is considered In-Network. Participants can register with Doctor on Demand and connect face-to-face with a board-certified doctor or licensed psychologist on a smartphone, tablet, or computer through live video. Some of the medical and behavioral health conditions that may be treated include cold and flu, bronchitis, sinus issues, urinary tract infection, anxiety, depression, etc. Doctor on Demand providers can also prescribe medications (except controlled substances). For more information, visit w*ww.pebp.state.nv.us* or the *Summary of Medical Benefits*.

Services available include:

- Medical visit
- Psychologist visit
- Psychiatry visit

You may receive services from a provider who is in a different location using information and audio-visual communication technology. Telemedicine does not include communication through telephone, facsimile, or email.

Doctor on Demand physicians do not prescribe DEA controlled substances and may elect not to treat or prescribe other medications based on what is clinically appropriate. In a true medical emergency, such as chest pains, shortness of breath or broken bones, dial 911 or seek immediate medical attention as appropriate.

Alternatively, telemedicine may be available from in-network providers and is covered on the same basis as in-person services. It is your responsibility to ensure the providers you use are in-network providers. Failure to use in-network providers will result in a denial of benefits and higher cost to you.

This Plan also adheres to the provisions of NRS 695G.162 regarding telehealth.

Continued Coverage Following Termination of a Provider Contract

For serious health conditions not covered by the No Surprises Act, if a participant is receiving a

medically necessary course of treatment from an in-network provider and that provider leaves the network (except for termination due to medical incompetence or professional misconduct), and the participant and the provider agree that a disruption to the participant's current care may not be in the best interest or if continuity of care is not possible immediately with another in-network provider, this Plan will pay that provider at the same level they were being paid while contracted with this Plan's network, if the provider agrees. If the provider agrees to these terms, coverage may continue until:

- Such treatment is no longer medically necessary or no later than the 120th day after the date the contract is terminated; or
- If the medical condition is pregnancy, the 90th day after:
  - The date of delivery; or
  - If the pregnancy does not end in delivery, the date of the end of the pregnancy.

Transplant Services (Organ and Tissue)

Organ, bone marrow and tissue transplant coverage are provided only for eligible services directly related to non-experimental transplants of human organs or tissue, along with the facility and professional services, FDA-approved drugs, and medically necessary equipment and supplies.

This Plan will provide coverage for the donor when the recipient is a participant under this Plan. Coverage is provided for organ or tissue procurement and acquisition fees, including surgery, storage, and organ or tissue transport costs directly related to a living or nonliving donor (transport within the U. S. or Canada only). When the donor has medical coverage, his/her Plan will pay first and benefits under this Plan will be reduced by the amount payable under the donor's Plan.

Transplantation-related services require precertification (see the *Utilization Management* section of this document for details).

See the specific exclusions related to experimental and investigational services and transplants in the *Benefit Limitations and Exclusions* section.

This Plan provides for reimbursement of certain costs associated with travel and hotel accommodations for the patient and one additional person when the travels are associated with medical treatment for organ and tissue transplants performed at a Center of Excellence. Please refer to *Transplant Services* section for additional information. Expenses incurred for travel and hotel accommodations for organ and/or tissue transplants not performed at a Center of Excellence are not covered.

This Plan does not provide advance payment for travel expenses related to organ or tissue transplants.

See the specific exclusions related to experimental and investigational services and transplants in the *Benefit Limitations and Exclusions* section.

This Plan provides for reimbursement of certain costs associated with travel and hotel accommodations for the patient and one additional person when the travels are associated with medical treatment for organ and tissue transplants performed at a Center of Excellence. Please refer to *Schedule of Medical Benefits* section for additional information. Expenses incurred for travel and hotel accommodations for organ and/or tissue transplants not performed at a Center of Excellence are not covered.

This Plan does not provide advance payment for travel expenses related to organ or tissue transplants.

Use of Centers of Excellence for Transplant and Gastric (Bariatric) Procedures

This Plan requires participants to use an in-network Center of Excellence for transplant and bariatric weight/loss surgery. An appropriate Center of Excellence facility will be identified by the Plan's UM company and third-party Claims Administrator.

Travel Expenses

This Plan allows for the reimbursement of travel and hotel accommodation expenses permitted under IRS Regulation 213(d) and IRS Publication 502 for qualified medical expenses when the expenses are associated with the following services and have been pre-certified by the UM company:

- Organ and tissue transplants or bariatric weight loss surgery performed at a Center of Excellence; or
- Elective surgeries performed at exclusive hospitals/ambulatory facilities; and
- Outpatient infusion services if the UM company requires you to travel more than 50 miles one way for a service subject to precertification.
- Travel for a participant located in a State with restricted access to abortion to the nearest care center for abortion services covered under this Plan.

Participants are required to use the least expensive method of transportation. Participants who use their personal vehicle to travel to a Center of Excellence or to an exclusive hospital/ambulatory surgical facility or outpatient infusion center will be compensated for mileage from the participant's residence to and from the Center of Excellence or exclusive hospital/ambulatory surgical facility or outpatient infusion facility (based on an objective source such as Google Maps) at the standard mileage reimbursement rate for medical travel.

This Plan incorporates the travel expense reimbursement guidelines established in IRS Regulation 213(d) and IRS Publication 502.

NOTE: The Plan Administrator or its designee has full authority to approve or deny all or part of your travel expenses. The denial of travel expenses cannot be appealed.

Excluded Travel Expenses:

The following are specifically excluded from reimbursement under any circumstances (other expenses not included below may be denied if they are not preapproved):

- Alcoholic beverages.
- Car maintenance.
- Vehicle insurance.
- Flight insurance.
- Cards, stationery, stamps.
- Clothing.
- Dry cleaning.
- Entertainment (cable televisions, books, magazines, movie rentals).
- Flowers.
- Household products.
- Household utilities, including cell phone charges, house cleaner, baby-sitter, or day care services.
- Kennel fees.
- Laundry services.
- Meals (insomuch as it is excluded under the IRS Publication 502 and Regulations under 213(d).
- Security deposits.
- Toiletries.
- Travel expenses related to a facility or provider that is not a certified Center of Excellence, exclusive hospital/ambulatory surgical facility, or outpatient infusion facility; and
- Travel expenses incurred on or after one year following surgery are not eligible for reimbursement.
- Travel expenses are subject to the annual cost sharing requirements.

Note: PEBP will not reimburse travel or any other expense to any participant covered under PEBP's Exclusive Provider Organization Plan, the self-funded Consumer Driven Health Plan (CDHP), or the Low Deductible PPO Plan twice for any service or event.

PEBP does not provide advance payment for travel expenses.

Pre-Approval of your Travel Expenses

Unless there are extenuating circumstances, travel expenses must be pre-approved by PEBP or its designee. Travel expenses not pre-approved by PEBP or its designee will not be eligible for reimbursement.

If the participant is unable to obtain pre-approval by PEBP or its designee because the organ or tissue transplant required immediate travel, the participant may submit all associated travel costs to PEBP or its designee after the transplant surgery for consideration. The participant should designate someone to notify PEBP or its designee regarding the emergency travel and the

circumstances surrounding such travel. Travel claims must be submitted within 12 months of the date of surgery to be considered eligible. All other requests for travel expenses require pre-approval.

Pre-approval will provide an approximation of your travel reimbursement. Final reimbursement will be based on actual expenses using the actual number of days and travel times and may differ from the pre-approved approximation. The Pre-approval Travel Expense Request form is available at www.pebp.state.nv.us.

Submitting your Travel Expense Receipts

A claim for travel expense reimbursement must be submitted to PEBP on a Travel Expense Reimbursement claim form. All relevant sections of the form must be completed including the start and end times, destination, and purpose of trip. T

Travel expense reimbursement claims should be accompanied by original itemized receipts which include the name(s) of the person(s) incurring the expense.

Reimbursement of eligible travel expenses, including any eligible travel expenses relating to a travel companion, will be payable to the primary participant (employee or retiree) and not to the service vendor (credit card company, hotel, hospital, restaurant, etc.).

Schedule of Prescription Drug Benefits

Benefits for prescription drugs are provided through the prescription drug plan administered by the Pharmacy Benefit Manager, Express Scripts. Coverage is provided only for those pharmaceuticals (drugs and medicines) approved by the U. S. Food and Drug Administration (FDA) as requiring a prescription and FDA approval for the condition, dose, route, duration, and frequency, if prescribed by a physician or other practitioner.

The following includes explanations and limitations that apply to each benefit; however, the explanations and limitations may not include every limitation. For more information relating to a specific benefit, refer to Utilization Management (for any precertification requirements), Exclusions, Key Terms and Definitions and other sections that may apply to a specific benefit.

For helpful tools such as "Price a Medication" see the *Participant Contact Guide* section or go to the PEBP website at *www.pebp.state.nv.us.*

Some over the counter (OTC) drugs and prescription drugs are eligible to be covered under the Plan's Preventive Care Services benefit in accordance with the Affordable Care Act; whereby, the Plan will waive the Copay and Deductible and products are paid at 100%. Examples include aspirin, folic acid, smoking cessation products and female oral contraceptives. Please contact Express Scripts for more information.

Certain OTC female contraception products are covered when presented with a prescription from your physician to your pharmacy. These types of products include the female condom, sponges, and spermicides. Refer to the *Women's Preventive Care* section for more information or call Express Scripts, whose contact information is in the *Participant Contact Guide*.

Many vaccines may also be administered through the prescription drug benefit with certain pharmacies. Contact the pharmacy benefit manager listed in the *Participant Contact Guide* or visit *www.express-scripts.com* to check vaccine coverage and locate your nearest in-network pharmacy.

Coverage is also provided for, but not limited to:

- COVID-19 vaccinations and medications
- Vaccinations such as shingles, HPV, Flu, pneumonia, Herpes Zoster, TDAP (tetanus, diphtheria, and pertussis -whoopingcough)
- Prenatal & pediatric prescription vitamins
- Prescription female oral contraceptives
- Insulin, diabetic supplies (such as lancets, syringes, test strips), insulin pumps, and insulin pump supplies.
    - Insulin pumps and supplies are covered under the pharmacy benefit's base day and quantity limits, subject to copayments, deductibles, or coinsurance.

- Orally Administered Chemotherapy: The Copayment or Coinsurance amount for orally administered chemotherapy drugs will be consistent with the drug's formulary tier for retail, home delivery and Specialty pharmacy; and in accordance with NRS 695G.167, the cost will not exceed $100 per prescription. For more information, see *Key Terms and Definitions* section.
- Chronic medication synchronization per NRS 695G.1665
- Topical Ophthalmic Products NRS 695G.172. Refills of topical ophthalmic products will be covered when medically necessary, including when requested: (a) After 21 days or more but before 30 days after receiving any 30-day supply of the product; (b) After 42 days or more but before 60 days after receiving any 60-day supply of the product; or (c) After 63 days or more but before 90 days after receiving any 90-day supply of the product.
- Medically necessary prescription drugs to treat sickle cell disease and its variants (NRS 695G.174).
- Human Papillomavirus testing and vaccination under NRS 695G.171.

Preventive Drug Benefit Program

The Preventive Drug Benefit Program provides participants access to certain preventive drugs without having to meet a Deductible and will instead only be subject to Coinsurance. Coinsurance paid under the benefit will not apply to the Deductible but will apply to Out-of-Pocket Maximum costs. The medications covered under this benefit are limited to those preventive drugs identified by Express Scripts. Preventive drugs include categories of prescription drugs that are used for preventive purposes for conditions such as hypertension, asthma, and high cholesterol. A list of eligible preventive drugs covered under this benefit can be found by logging on to www.pebp.state.nv.us or by contacting Express Scripts located in the Participant Contact Guide section.

The plan adheres to NRS 695G.1715 regarding contraception and related health services.

Specialty Drugs

Specialty drugs are used to treat complex conditions, such as cancer, hemophilia, hepatitis C, immune deficiency, multiple sclerosis, rheumatoid arthritis, etc. Specialty drugs and prescriptions are limited to a 30-day supply. Specialty drugs must be filled through Accredo, an Express Scripts Specialty Pharmacy (see the *Participant Contact Guide)*. Plan participants are encouraged to register with the Accredo Specialty Pharmacy before filling their first prescription for a specialty drug. Check with Express Scripts to determine if your prescription is considered specialty.

Certain drugs fall into a category called specialty drugs. Specialty drugs are available only through the Specialty Pharmacy listed in the *Participant Contact Guide* section, and prescriptions are limited to a 30-day supply. Plan participants are encouraged to register with the Specialty Pharmacy before filling their first prescription for a specialty drug. Contact Express Scripts to determine if your prescription is considered specialty.

Special pharmaceuticals, which include injectables, oral medications, and medications given by

other routes of delivery, may be delivered in any setting. Special pharmaceuticals are pharmaceuticals that typically have:

- Limited access.
- Treat complex medical conditions.
- Complicated treatment regimens.
- Compliance issues.
- Special storage requirements; or
- Manufacturer reporting requirements.

This Plan's Pharmacy Benefit Manager maintains a list of special drugs classified as special pharmaceuticals. For information regarding special pharmaceuticals, contact the Pharmacy Benefit Manager listed in the *Participant Contact Guide*.

Copayment assistance (manufacturer-funded patient assistance) for specialty drugs will not apply toward your Deductible and Out-of-Pocket Maximum.

Preferred Retail Pharmacy Network

For short-term prescriptions, such as antibiotics, use a Preferred Retail Pharmacy (for lower copays) or a Non-Preferred Retail Pharmacy (where you will pay $10 extra for each short-term prescription). Your Preferred Retail Pharmacy Network has more than 34,000 pharmacies consisting of approximately 50% independent pharmacies in addition to grocers and other stores.
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To find a preferred pharmacy near you, register or log in to *express-scripts.com/findapharmacy* or call Express Scripts' Member Services at 855-889-7708.

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90-Day Retail and Home Delivery Program

The Smart90 program is a feature of your prescription plan, managed by Express Scripts. With this program, you have two ways to get up to a 90-day supply of your long-term medications (those you take regularly for ongoing conditions). You can fill your long-term prescriptions through home delivery from the Express Scripts Home Delivery Pharmacy or at a retail pharmacy in the Smart90 network.

You will need to move your long-term medications to both a 90-day supply and to either a participating retail pharmacy or Express Scripts Home Delivery Pharmacy. If, after your second 30-day supply courtesy fill of your long-term medication, you do not make the switch you will pay a higher cost for your prescription medication and will not receive credit toward your Deductible or Out-of-Pocket Maximum.

Smart90 Retail Pharmacy

To locate a participating Smart90 Retail Pharmacy or an Preferred Retail Network Pharmacy, log in to the E-PEBP Portal located at www.pebp.state.nv.us and select *Express Scripts*. You can also get pharmacy information by calling Express Scripts' Member Services at 855-889-7708. You can transfer your medications easily in-store, by phone or online.

Express Scripts Home Delivery:

You may use home delivery through the Express Scripts Home Delivery Pharmacy to receive a 90-day supply of your maintenance medications and have them mailed to you with free standard shipping. Not all drugs are available via mail order. Check with Express Scripts for further information on the availability of your prescription medication. Enrolling in home delivery is easy! First, log in to *express-scripts.com.*

If you are enrolling a new prescription in home delivery:

- **Contact your doctor** and ask them to e-prescribe a 90-day prescription directly to ExpressScripts
- **OR send a request** by selecting "Forms" or "Forms & Cards" from the "Benefits" menu,print and mail-order form and follow the mailing instructions
- **OR call** Express Scripts' Member Services at 855-889-77058 and they will contact yourdoctor for you if you are enrolling a current prescription:

Transfer retail prescriptions to home delivery by **clicking "Add to Cart"** for eligible prescriptions and check out. You can also refill and renew prescriptions. Express Scripts will contact your doctor and take care of the rest.

Check **Order Status** to track the shipping of your prescriptions. After we receive your prescription from your doctor, you will receive your medication within 7 days. Please keep in mind, longer delivery times may be due to additional correspondence need with prescribers, medication availability and/or delivery times from the shipping vendor.

Generics Preferred Program

When your doctor prescribes a brand-name drug and a generic substitute is available, you will automatically receive the generic drug unless:

- Your doctor writes "dispense as written" (DAW) on the prescription; or
- You request the brand-name drug at the time you fill your prescription.

If you choose generic medicines, you get safe medicines at the lowest cost. Your copayment for the generic drug will be less than the copayment for the brand-name drug.

If a generic is available, but you or your doctor request the brand-name drug, you will pay the applicable brand copayment, plus the full difference in cost between the brand-name drug and

the generic equivalent. This difference in cost is referred to as the ancillary fee. The ancillary fee is in addition to the copayment, so the cost could exceed the copayment maximum.

SaveonSP Program

As part of your prescription drug plan, Nevada Public Employees' Benefits Program has partnered with an Express Scripts' copay assistance program, SavOnSP, to help save money on certain specialty medications. Through the SaveonSP Program, manufacturer-funded assistance is available to help assisting members with the cost of the Program drug(s) is reimbursed by the manufacturer at no cost to the participant.

The medications included in the SaveonSP Program are classified as Non-Essential Health Benefits under the Affordable Care Act. The cost of these drugs will not be applied towards satisfying your deductible or out- of-pocket maximum.

Members currently taking a medication, or those who will be taking a medication, captured under this Program are eligible to participate.

- Select medications on the *Non-Essential Benefit Specialty Drug List* will be free of charge($0) to members who participate.
- Prescriptions must be filled through Accredo Specialty Pharmacy.
- The medications and associated copays included in this program are subject to thePharmacy Benefit Manager's clinical rules.
- If the medication you are taking is on the SaveOnSP *Non-Essential Benefit Specialty DrugList* and you wish to participate, call SaveOnSP at 1-800-683-1074.
- The SaveonSP Program drug list can be found at *www.saveonsp.com/pebp*

Participation in the SaveOnSP Program is voluntary; however, if you are taking or will be taking a medication that is on the Non-Essential Benefit Specialty Drug List, and you choose not to participate in the SaveOnSP Program, you will be responsible for the copay outlined in the SaveonSP Program Drug List and that cost will not apply toward your Deductible or Out-of-Pocket Maximum.

Hinge Health Digital Musculoskeletal (MSK) Care program

Hinge Health's Digital MSK Program is offered through Express Scripts' and is designed to help members with Musculoskeletal Care using digital technology. The program offers qualifying participants virtual physical therapy focusing on prevention, acute injury, chronic and surgical care programs via digital physical therapy plus additional physical and behavioral support through a full clinical-care team. Members will also have access to other services, such as, pelvic floor therapy, advanced wearable technology for electrical nerve stimulation and pain relief, expert medical opinion consultation, health education, etc.

Members will complete a screener to assess which Digital MSK ClinicTM programs is right for them. The questionnaire screener leverages data analytics combined with a dedicated clinical care team review to match each member's personal needs with the right program tools and resources. This program is managed by Express Scripts and is provided at no cost to members.

Extended Absence Benefit

If you are going to be away from your home for an extended period, either in the country or outside of the country, you may obtain an additional fill (30 or 90-day supply) of your prescription drugs from your local retail or mail order pharmacy. This limited benefit must be requested in advance by the participant to the pharmacy benefit manager listed in the *Participant Contact Guide*. A maximum of two (2) early refills are allowed every 180 days. You may be required to obtain a new written prescription from your physician and any necessary prior authorizations.

Out-of-Network Pharmacy Benefit

Prescriptions filled at a domestic (inside the United States) out-of-network pharmacy location, are not authorized for reimbursement under the prescription drug Plan. Prescription drugs must be filled at a participating in-network pharmacy location.

Express Scripts offers helpful tools that allow participants to manage their prescriptions. Go to www.express-scripts.com or download the free mobile app and have your identification card available to register. The "Price a Medication" menu option under "Prescriptions" is used to determine estimated Out-of-Pocket cost. From this menu option, a prescription savings program called *My Rx Choices* is available to view side-by-side medication comparisons showingpotential savings with lower-cost alternatives along with any applicable coverage alerts such as"prior authorization required". See the *Participant Contact Guide* section or go to the PEBP website at *www.pebp.state.nv.us*.

Out-of-Country Emergency Medication Purchases

This Plan may cover emergency prescription drugs purchased if you reside in the United States and travel to a foreign country. You will need to pay for the drug at the time of purchase and later submit for reimbursement from the Pharmacy Benefit Manager. Prescription drug purchases made outside of the United States are subject to Plan provisions, limitations and exclusions, clinical review, and determination of medical necessity. The review will also include regulations determined by the FDA. Out-of-Country medication purchases are only eligible for reimbursement while traveling outside of the US.

If your purchase is eligible for reimbursement, you must use the Direct Claim Form available from the prescription drug plan administrator. Direct Claim Forms may be requested from the prescription drug plan or obtained by logging in to *www.express-scripts.com*. In addition to the Direct Claim Form, you are required to provide:

- A legitimate copy of the written prescription completed by your physician
- Proof of payment from you to the provider of service (typically your credit card

invoice)

- Prescription and receipt must be translated to English and include the Americanequivalent National Drug Code for the prescription purchased
- Reimbursement request must be converted to United States dollars

The claim will be processed based on the American equivalent National Drug Code and charged based upon that drug copay tier. If an American equivalent National Drug Code does not exist, the claim will be denied.

Benefit Limitations and Exclusions

This Plan does not cover certain services. This chapter lists the general medical and pharmacy benefit exclusions of this Plan. Any amount you pay toward services that are not covered or otherwise excluded will not count toward your out-of-pocket maximum. Additional exclusions that apply to only a service or benefit are listed in the description of that service or benefit in the *Schedule of Medical Benefits* sections. This list is not all-inclusive; if you have questions about a service or supply, contact the Claims Administrator listed in the *Participant Contact Guide.*

Expenses That Do Not Accumulate Toward Your Out-of-Pocket Maximum

The following services do not accumulate toward the out-of-pocket maximum, and you will be responsible for paying these expenses out of your own pocket.

- All expenses for medical and pharmacy services and supplies that are not covered by the Plan, to include but not limited to, expenses that exceed the CDHP network contract rate, services listed in the *Benefit Limitations and Exclusions* section.
- All charges in excess of the usual and customary charge determined by the Plan Administrator.
- Any additional amounts you must pay because you failed to comply with the utilization management requirements described in the *Utilization Management* section.
- Benefits exceeding those services or supplies subject to maximum individual or lifetime limit(s) for certain eligible medical expenses as listed in the *Schedule of Medical Benefits*; and
- Certain wellness or preventive services that are paid by this Plan at 100% do not accumulate towards the out-of-pocket maximum.

This list is not all inclusive and may not include certain services and supplies that are not listed above.

Benefit Limitations

In addition to the exclusions listed below, refer to the *Schedule of Medical Benefits* sections for the maximum individual or lifetime limit(s) and any Plan Year limit applicable to certain covered expenses. Plan Year limits are met by days, hours, visits, or dollar limits paid under all components of the Plan.

Lifetime Maximum

This Plan imposes a lifetime maximum on some health care services and procedures. For information on the lifetime maximums, refer to the *Schedule of Medical Benefits* sections.

Exclusions Under the Medical Plan

The following is a list of services and supplies or expenses not covered by this Plan. The Plan Administrator and its designees will have discretionary authority to determine the applicability of these exclusions and terms of the Plan and determines eligibility and entitlement to Plan

benefits. Any amount you pay toward services that are not covered or otherwise excluded will not count toward your out-of-pocket maximum.

Abortion: Elective termination of pregnancy (abortion) is excluded from the plan, other than medically indicated abortions that are medically necessary to save the life of the mother.

Alternative/Complimentary Health Care Exclusions: Expenses for chelation therapy (except as may be medically necessary for treatment of acute arsenic, gold, mercury, or lead poisoning) and for diseases due to clearly demonstrated excess of copper or iron. Expenses for prayer, religious healing, or spiritual healing, except services provided by a Christian Science Practitioner. Expenses for naturopathic, Naprapathy services or treatment/supplies. Expenses for homeopathic treatments/supplies that are not FDA approved.

Autopsy: Expenses for an autopsy and any related expenses, except as required by the Plan Administrator or its designee.

Bariatric and Overweight Surgery: The Plan's individual lifetime maximum is one (1) bariatric surgery while covered under any current or previous PEBP self-funded health plan.

Bariatric and Overweight Surgery Not Performed at a Center of Excellence Provider: Benefits are excluded for bariatric/weight loss surgery performed at an Out-of-Network facility, Out-of-Network surgeon, or when Out-of-Network ancillary providers are used, unless covered under the No Surprises Act. PEBP or its designee will determine the In-Network Center of Excellence facility.

Behavioral Health Care Exclusions

- Expenses for hypnosis and hypnotherapy.
- Expenses for behavioral health care services related to: adoption counseling; non-medically necessary court-ordered behavioral health care services (except pursuant to involuntary confinement under a state's civil commitment laws); custody counseling; dance, poetry, or art therapy; developmental disabilities; dyslexia; learning disorders; attention deficit disorders (with or without hyperactivity, except when the services are for diagnosis, the prescription of medication as prescribed by a physician or other health care practitioner, or when accompanied by a treatment plan as submitted to the Plan or its designee) or the treatment is related to the management of ADD/ ADHD without prescription drugs and is approved by the Plan or its designee; family planning counseling; marriage, couples and or sex counseling; intellectual disability; pregnancy counseling; vocational disabilities, and organic and non-organic therapies including (but not limited to) crystal healing, EST, primal therapy, L-Tryptophan, vitamin therapy, religious/spiritual, etc.
- Expenses for tests to determine the presence of or degree of a person's dyslexia or learning disorder unless the visit meets the criteria for benefits payable for the diagnosis or treatment of Autism Spectrum Disorders.

Complications of a non-covered service: Expenses for care, services or treatment required because of complications from a treatment or service not covered under this Plan, except complications from an abortion.

Concierge membership fees: Expenses for fees described or defined as membership, retainer or premiums that are paid to a concierge medical practice to have access to the medical services provided by the concierge medical practice.

Controlled Substance or Intoxicated: (NRS 695G.405) Services/Treatments which involves an injury to which a contributing cause was the insured's commission of or attempt to commit a felony, except if a result of a medical or behavioral health condition, or domestic violence, even if the condition was not diagnosed at the time of the injury. See NRS 695G.405..

Corrective Appliance, Orthotic Device Expenses, and Appliances: Any items that are not corrective appliances, orthotic devices or orthotic braces that straighten or change the shape of a body part, prosthetic appliances, or durable medical equipment (as each of those terms is defined in the *Key Terms and Definitions s*ection), including, but not limited to, personal comfort items like air purifiers, humidifiers, electric heating units, swimming pools, spas, saunas, escalators, lifts, motorized modes of transportation, pillows, orthopedic mattresses, water beds, and air conditioners are excluded. Expenses for cranial helmets are excluded except for cranial helmets used to facilitate a successful post-surgical outcome. Expenses for replacement of lost, missing, or stolen, duplicate or personalized corrective appliances, orthotic devices, prosthetic appliances, or durable medical equipment are not covered. Oxygen provided while traveling on an airline and portable oxygen concentrators that are supplied for purchase or rent specifically to meet airline requirements are excluded.

Cosmetic Services and Surgery: The Plan excludes expenses for cosmetic services and surgery, or any drugs used for cosmetic purposes, including but not limited to health and beauty aids unless explicitly noted in the Covered Services section

Complications resulting from Cosmetic Services or Surgery are not covered.

There is no coverage for travel costs.

Costs of Reports, Bills, etc.: Expenses for preparing medical reports, bills or claim forms; mailing, shipping, or handling expenses; and charges for broken/missed appointments, general telephone calls not including telehealth, or photocopying fees.

Court-Ordered Treatment: Medical and psychiatric evaluations, examinations, or treatments, psychological testing, therapy, laboratory and other diagnostic testing and other services including hospitalizations or partial hospitalizations and residential treatment programs that are ordered as a condition of processing, parole, probation, or sentencing are excluded, unless the Plan Administrator or its designee determines that such services are independently medically necessary.

Custodial Care: Expenses for custodial care as defined in the *Key Terms and Definitions* section, regardless of where they are provided, including, without limitation, adult day care, child day care, services of a homemaker, or personal care, sitter/companion service, including any service that can be learned to be performed or provided by a family member who is not a physician, nurse or other skilled health care provider are not covered, even if they are medically necessary.

Services required to be performed by physicians, nurses or other skilled health care providers are not considered to be provided for custodial care services and are covered if they are determined by the Plan Administrator or its designee to be medically necessary. However, any services that can be learned to be performed or provided by a family member who is not a physician, nurse or other skilled health care provider are not covered, even if they are medically necessary.

Dental Services: Expenses for dental prosthetics or dental services or supplies of any kind, even if they are necessary because of symptoms, congenital anomaly, illness, or injury affecting the mouth or another part of the body.

Except as described as an inclusion in the Schedule of Medical Benefits, services involving treatment to the teeth; extraction of teeth; repair of injured teeth; general dental services; treatment of dental abscesses or granulomas; treatment of gingival tissues (other than for tumors); dental examinations; restoration of the mouth, teeth, or jaws because of injuries from biting, chewing, or accidents; artificial implanted devices; braces; periodontal care or surgery; teeth prosthetics and bone grafts regardless of etiology of the disease process; and repairs and restorations except for appliances that are medically necessary to stabilize or repair teeth after an injury; dental and or medical care including mandibular or maxillary surgery, orthodontia treatment, oral surgery, pre-prosthetic surgery, any procedure involving osteotomy to the jaw, and any other dental product or service except as set forth in the Schedule of Medical Benefits.

Coverage for dental services as the result of an injury to teeth may be extended under the medical Plan to a maximum of two (2) years following the date of the injury. Restorations past the two-year time frame will be considered under the dental benefits described in the PEBP Self-Funded Dental PPO Plan Master Plan Document available at www.pebp.state.nv.us.

Treatment to the gums and treatment of pain or infection known or thought to be due to dental or medical cause and in close proximity to the teeth or jaw, braces, bridges, dental plates or other dental orthosis or prosthesis, including the replacement of metal dental fillings; and other supplies and services including but not limited to cosmetic restorations, implants, cosmetic replacements of serviceable restorations, and materials (such as precious metals).

Orthodontia is a specific Plan exclusion.

Drugs, Medicines, Nutrition or Devices:

- Pharmaceuticals requiring a prescription that have not been approved for use by the U.S. Food and Drug Administration (FDA); have not been prescribed for a medically necessary indication or are Experimental and/or Investigational as defined in the *Key Terms and Definitions s*ection.

- Non-prescribed, non-Legend and over the counter (OTC) drugs or medicines (except as preventive care medications required by the Affordable Care Act).
- Foods and nutritional supplements including (but not limited to) home meals, formulas, foods, diets, vitamins, herbs, and minerals (regardless of whether they can be purchased OTC or whether they require a prescription), except when provided during hospitalization; prenatal vitamins or minerals requiring a prescription;
- Special Food Product (as defined in the *Key Terms and Definitions* section), except for the benefit described as covered under Special Food Product in the *Schedule of Medical Benefits* section or elsewhere in this document under the section titled *Obesity Care Management Program*;
- Naturopathic, Naprapathy, or homeopathic treatments/substances.
- Weight control or anorexiants, except those anorexiants used for treatment of children with attention deficit hyperactivity disorder (ADHD) or individuals with narcolepsy or where otherwise noted in this document under the section titled *Obesity Care Management Program*;
- Compounded Prescriptions in which there is not at least one ingredient that is a Legend Drug requiring a Prescription, as defined by federal or state law.
- Take-home drugs or medicines provided by a hospital, emergency room, ambulatory surgical facility/center, or other health care facility.
- Vaccinations, immunizations, inoculations, or preventive injections that are not covered under the Summary of Medical Benefits section.
- Marijuana and any derivative, including CBD, THC, edibles, etc. are not a covered benefit under this Plan.
- Non-prescription devices and drugs purchased from retail or mail-order pharmacies are not payable under the prescription drug program.
- Drugs to enhance athletic performance such as anabolic steroids (including off-labeled growth hormone). Coverage for human growth hormone or equivalent is excluded unless specifically covered and described in the *Summary of Medical Benefits*.
- Non-prescription male contraceptives, e.g., condoms.
- Dental products such as topical fluoride preparations and products for periodontal disease except as a preventive service required under the Affordable Care Act.
- Hair removal or hair growth products (*i.e., Propecia, Rogaine, Minoxidil, Eflornithine, etc.*).
- Vitamin A derivatives (retinoids) for dermatologic use.
- Vitamin B-12 injections (except for pernicious anemia, other specified megaloblastic anemias not elsewhere classified, anemias due to disorders of glutathione metabolism, post-surgery care or other b-complex deficiencies), antihemophilic factors including tissue plasminogen activator (TPA), acne preparations, and laxatives (unless otherwise specified in the Schedule of Medical Benefits.
- Anti-aging treatments (even if FDA-Approved for other clinical indications)

Durable Medical Equipment:

See the exclusions related to Corrective Appliance, Orthotic Device Expenses, and Appliances.

Educational Services: Expenses for educational/vocational services, supplies or equipment including (but not limited to) computers, software, printers, books, tutoring, visual aids, auditory aides, and speech aides, programs to assist with auditory perception or listening/learning skills, programs/services to remedy or enhance concentration, memory, motivation, or self-esteem, etc. (even if they are required because of an injury, illness, or disability of a covered individual).

Electronic cigarettes: The Plan does not cover electronic cigarettes.

Employer-Provided Services: Expenses for services rendered through a medical department, clinic or similar facility provided or maintained by you or your covered dependents' employer; or for benefits otherwise provided under this Plan or any other plan that PEBP contributes to or otherwise sponsors (e.g., HMOs).

Expenses Exceeding Maximum Plan Benefits: Expenses that exceed any Plan benefit limitation or Plan Year maximum benefits as described in this document.

Expenses Exceeding Usual and Customary Charges, the Plan's Maximum Allowable Charge, Prevailing Rates and Plan Contracted Rates: Any portion of the expenses for covered medical services or supplies that are determined by the Plan Administrator or its designee to exceed the Plan's Maximum Allowable Charge, Usual and Customary Charge, prevailing rates or EPO contracted rate as defined in the *Key Terms and Definitions* section.

Expenses for Which a Third-Party Is Responsible: See "Third-Party Liability" of the Health and Welfare Wrap document that can be found on www.pebp.state.nv.us (NAC 287.755)**.**

Expenses Incurred Before or After Coverage: Expenses for services rendered or supplies provided either before the patient became covered under the Plan or after the date the patient's coverage ends, except under those conditions described in COBRA Continuation Coverage.

Experimental and/or Investigational Services: Unless mandated by law, expenses for any medical services, supplies, drugs, or medicines that are determined by the Plan Administrator, UM company, or its designee to be experimental and/or investigational services.

Fertility and Infertility Treatment:
Except as otherwise specified in the Schedule of Medical Benefits section, all other costs incurred for reproduction by artificial means or assisted reproductive technology (such as in-vitro fertilization, or embryo transplants) ~~except services directly related to artificial insemination services up to the maximum benefit limit are excluded~~. This exclusion includes treatments, testing, services, supplies, devices, or drugs intended to produce a pregnancy; the promotion of fertility including, but not limited to, fertility testing (except as otherwise covered and described above); serial ultrasounds; services to reverse voluntary surgically-induced infertility; reversal of surgical sterilization; any service, supply, or drug used in conjunction with or for the purpose of an artificially induced pregnancy, test-tube fertilization; the cost of donor sperm or eggs; in-vitro fertilization and embryo transfer or any artificial reproduction technology or the freezing of sperm or eggs or storage costs for frozen sperm, eggs, or embryos; including, but not limited to, determining, evaluating, or enhancing the physical or psychological readiness for pregnancy,

procedures to improve the participant's ability to become pregnant or to carry a pregnancy to term; and any payment made by or on behalf of a participant who is contemplating or has entered into a contract for surrogacy to a provider or individual related to any services potentially included in the scope of surrogacy services; sperm donor for profit or prescription (infertility) drugs; or GIFT or ZIFT procedures, low tubal transfers, or donor egg retrieval are also excluded

Foot/Hand Care:
Expenses for non-symptomatic foot care such as the removal of warts (except plantar warts); corns or calluses; and including but not limited to podiatry treatment of bunions, toenails, flat feet, fallen arches, and chronic foot strain; and expenses for routine foot care (including but not limited to: trimming of toenails, removal of corns and callouses, preventive care with assessment of pulses, skin condition and sensation) or hand care, (including manicure and skin conditioning), unless the Plan Administrator or its designee determines such care to be medically necessary.

Routine foot care from a podiatrist for treatment of foot problems such as corns, calluses and toenails are payable for individuals with a metabolic disorder such as diabetes, or a neurological or peripheral-vascular insufficiency affecting the feet.

Gender Dysphoria and/or Gender Services: Certain procedures associated with gender dysphoria treatment and/or gender surgery found to be non-medically necessary in the Treatment for Gender Dysphoria section above are not covered.

- No more than one gender surgery in the individual's lifetime covered under any current or previous PEBP health plan.
- There is no coverage for travel costs.
- A surgery to reverse a surgery to treat gender dysphoria will not be covered.

Genetic Testing and Counseling: Coverage is not available for tests solely for research, or for the benefit of individuals not covered under this Plan.

Expenses for genetic testing and counseling are excluded, unless otherwise specified in this Plan's Schedule of Medical Benefits.

Growth Hormone: Coverage for off-labeled growth hormone.

Gym Fees: Fees by personal trainers or gym or health club memberships, exercise programs, or exercise physiologists, even if recommended by a professional to treat a medical condition.

Hair: Expenses for or related to hair removal, hair transplants and other procedures to replace lost hair or to promote the growth of hair, including prescription and non-prescription drugs such as Minoxidil, Propecia, Rogaine, Eflornithine; or for hair replacement devices, including (but not limited to) wigs, toupees and/or hairpieces or hair analysis. Patients undergoing chemotherapy may be able to receive benefits for some hair replacement devices, as listed above.

Hearing Care: Special education and associated costs in conjunction with sign language education for a patient or family members.

Hearing Aids: Over the Counter hearing aids are excluded from the Plan.

Home Birth/Delivery: Planned birth/delivery at home and associated services are not covered by this Plan. Guidelines for Perinatal Care published by the American Academy of Pediatrics and American College of Obstetricians and Gynecologists (ACOG) that the hospital, including a birthing center within the hospital complex, or a freestanding birthing center, provides the safest setting for labor, delivery, and the postpartum period. The use of other settings is not covered by this Plan. Facilities providing obstetrical care should have the services listed as essential components of a Level 1 hospital.

Home Health Care:

- Expenses for any home health care services that are not medically necessary, other than part-time, intermittent skilled nursing services and supplies.
- Expenses for a homemaker, custodial care, childcare, adult care, or personal care attendant, except as provided under the Plan's hospice coverage.
- Expenses for any home health care services that is not provided by an organization or professional licensed by the state to render home health services.
- Over-the-counter medical equipment supplies or any prescription drugs, except otherwise provided in the Summary of Medical Benefits and Schedule of Medical Benefits.
- Expenses for any services provided substantially or primarily for the participant's convenience or the convenience of a caregiver.

1. **Hospital Employee, Medical Students, Interns or Residents:** Expenses for the services of an employee of a hospital, skilled nursing facility or other health care facility, when the facility is obligated to pay that employee.

Illegal Act: Expenses incurred by a covered individual for injuries resulting from commission (or attempted commission by the covered individual) of an illegal act as determined by the plan administrator which involved violence or threat of violence to another person, or in which any weapon or explosive is used by the covered individual unless such injury is the result of a physical or mental health condition or domestic violence. The Plan Administrator's determination that this exclusion applies shall not be affected by any prosecution, or acquittal of (or failure to prosecute) the covered individual in connection with the acts involved.

Internet/Virtual Office Visit: Expenses related to an online internet consultation with an out-of-network physician or other health care practitioner (also called a virtual office visit/consultation), physician-patient web service or physician-patient e-mail service (including receipt of advice, treatment plan, prescription drugs or medical supplies obtained) from an online internet provider who is not a participating provider in the Plan network, except as specifically provided.

Maternity/Family Planning:

- Contraception: Expenses related to prescription or non-prescription male contraceptive drugs and devices such as condoms.

- Termination of Pregnancy: Expenses for elective termination of pregnancy (abortion) unless the attending physician certifies the health of the mother would be endangered if the fetus were carried to term, and complications of such termination
- Childbirth courses.
- Expenses related to delivery associated with a pregnant dependent child, except for expenses related to complications of pregnancy.
- Expenses related to cryo-storage of umbilical cord blood or other tissue or organs.
- For nondurable supplies.
- Reversal of prior sterilization procedures, including, but not limited to tubal ligation and vasectomy reversals.

Medically Unnecessary Services: Services or supplies determined by the Plan Administrator or its designee not to be medically necessary, as defined in the *Key Terms and Definitions* section.

Modifications of Homes or Vehicles: Expenses for construction or modification to a home, residence or vehicle required because of an injury, illness, or disability of a covered individual, including, without limitation, any construction or modification (e.g., ramps, elevators, chair lifts, swimming pools, spas, air conditioning, asbestos removal, air filtration, handrails, emergency alert system, etc.).

No-Cost Services: Expenses for services rendered or supplies provided without cost, or for which there would be no charge if the person receiving the treatment were not covered under this Plan.

No Provider Recommendation or Order: Expenses for services rendered or supplies provided that are not recommended or prescribed by a physician or other licensed provider acting within the scope of their license.

Non-Emergency Hospital Admission: Care and treatment billed by a hospital for a non-medical emergency admission on a Friday or Saturday unless surgery is performed within 24 hours of the admission.

Non-Emergency Travel and Related Expenses: Expenses for and related to non-emergency travel or transportation (including lodging, meals, and related expenses) of a health care provider, participant except where otherwise specified in the Utilization Management section for organ/ tissue transplants and bariatric weight loss surgery or certain surgeries performed in a surgery center, inpatient hospital or outpatient setting as determined by the Plan Administrator or the UM company.

Occupational Illness, Injury or Conditions Subject to Workers' Compensation: All expenses incurred by you or any of your covered dependents arising out of or during employment if the injury, illness, or condition is subject to coverage, in whole or in part, under any workers' compensation, or occupational disease (or similar) law.

Orthodontia: Expenses for any services relating to orthodontia evaluation and treatment even if the orthodontia services are provided as the result of an injury or illness.

Personal Comfort Items: Expenses for patient convenience, including (but not limited to) care of family members while the covered individual is confined to a hospital (or other health care facility, or to bed at home), guest meals, television, VCR/DVD, telephone, barber or beautician services, house cleaning or maintenance, shopping, birth announcements, photographs of new babies, etc.

Private Room in a Hospital or Health Care Facility: The use of a private room in a hospital or other health care facility, unless the facility has only private room accommodations, or unless the use of a private room is certified as medically necessary by the Plan Administrator or its designee.

Prophylactic Surgery or Treatment: Unless otherwise noted in this document, expenses for medical or surgical services or procedures, including prescription drugs and the use of prophylactic surgery, as defined in the *Key Terms and Definitions* section of this document, when the services, procedures, prescription of drugs, or prophylactic surgery is prescribed or performed for:

- Avoiding the possibility or risk of an illness, disease, physical or mental disorder or condition based on family history and/or genetic test results, in certain circumstances; or
- Treating the consequences of chromosomal abnormalities or genetically transmitted characteristics when there is an absence of objective medical evidence of the presence of disease or physical or mental disorder. Participants should use the Plan's UM company to assist in the determination of a proposed surgery to determine if it is or is not covered under this Plan.

NOTE: Some prophylactic surgeries may be covered under this Plan if certain criteria are met. Please refer to the *Schedule of Medical Benefits* section. For additional information, please contact this Plan's UM company or Claims Administrator.

Prophylactic drugs are excluded.

Rehabilitation Therapy (Inpatient or Outpatient):

- Expenses for educational, job training, vocational rehabilitation, and/or special education for sign language.
- Expenses for massage therapy, Rolfing, and related services.
- Expenses incurred at an inpatient rehabilitation facility for any inpatient rehabilitation therapy services provided to an individual who is unconscious, comatose, or in the judgment of the Plan Administrator or its designee, is otherwise incapable of conscious participation in the therapy services and/or unable to learn and/or remember what is taught, including (but not limited to) coma stimulation programs and services.
- Expenses for maintenance rehabilitation, as defined in the *Key Terms and Definitions* section.
- Expenses for speech therapy for functional purposes including (but not limited to) stuttering, stammering and conditions of psychoneurotic origin.

- Expenses for cognitive therapy are excluded unless related to short-term services necessitated by a catastrophic neurological event to restore functioning for activities of daily living.
- Therapies, psychological services, counseling, or tutoring services for developmental delay or learning disability.
- Treatment of that a federal or state law mandates that coverage be provided and paid for by a school district or other governmental agency.

Service Animals: Purchase, training, or maintenance of any type of service animal, even if designated as medically necessary.

Smoking/Tobacco Cessation or Tobacco Withdrawal: Expenses for non-prescription (over the counter) tobacco/smoking cessation products such as nicotine gum or patches, unless prescribed by a physician. There are no benefits payable for the use of electronic cigarettes. Prescription smoking/tobacco cessation products are payable under the prescription drug benefit as described in the *Schedule of Medical Benefits* section.

Stand-By Physicians or Health Care Practitioners: Expenses for any physician or other provider who did not directly provide or supervise medical services to the patient, even if the physician or practitioner was available on a stand-by basis.

Telephone Calls: Expenses for all telephone calls between a physician or other health care provider and any patient, other health care provider, UM company or vendor; or any representative of this Plan for any purpose whatsoever.

Transplant (Organ and Tissue) Experimental and/or Investigational:
Human organ and/or tissue transplants that are experimental and/or Investigational, including (but not limited to) donor screening, acquisition and selection, organ or tissue removal, transportation, transplants, post-operative services and drugs or medicines, and all complications thereof.

Non-human (Engrafted) organ and/or tissue transplants or implants, except heart valves.

Expenses incurred by the person who donates the organ or tissue, unless the person who receives the donated organ/tissue is the person covered by this Plan.

Travel Outside of the United States: Any services received outside the United States are excluded unless deemed to be urgent or emergency care.

Urgent Care: Any urgent care services that are received out-of-network are excluded unless the urgent care service is received out-of-area as defined in the *Key Terms and Definitions*.

Vision Care: Charges for the fitting and cost of visual aids, vision therapy, eye therapy, orthoptics

with eye exercise therapies, refractive errors including but not limited to eye exams and surgery done in treating myopia (except for corneal graft); ophthalmological services provided in connection with the testing of visual acuity for the fitting for eyeglasses or contact lenses, eyeglasses or contact lenses (except coverage for the first pair of eyeglasses or contact lenses following cataract surgery); and surgical correction of near or far vision inefficiencies such as laser and radial keratotomy are excluded, except as otherwise specified in this Plan's *Summary of Medical Benefits and Schedule of Medical Benefits*.

War or Similar Event: Expenses incurred because of an injury or illness due to you or your covered dependent(s)' participation in any act of war, either declared or undeclared, war-like act, riot, insurrection, rebellion, or invasion, except as required by law.

Weight Management and Physical Fitness:

- Medical or surgical treatment for weight-related disorders including (but not limited to) surgical interventions, dietary programs, and prescription drugs, except those services specified in the *Summary of Medical Benefits* and *Schedule of Medical Benefits.* Surgery for weight reduction must be performed at a Bariatric Center of Excellence. Expenses for weight loss surgery performed without a precertification from the UM company will be denied.
- Expenses related to programs such as Weight Watchers, Jenny Craig, Nutri-Systems, Slim Fast or the rental or purchase of any form of exercise equipment.
- Expenses for medical or surgical treatment of severe underweight, including (but not limited to) high calorie and/or high protein food supplements or other food or nutritional supplements, except in conjunction with medically necessary treatment of anorexia, bulimia, or acute starvation. Severe underweight means a weight more than 25 percent under normal body weight for the patient's age, sex, height, and body frame based on weight tables generally used by physicians to determine normal body weight.
- Expenses for memberships in or visits to health clubs, exercise programs, gymnasiums, and/or any other facility for physical fitness programs, including exercise equipment.
- One obesity related surgery per lifetime while covered under any PEBP self-funded medical Plan (e.g., LD PPO Plan, CDHP and Exclusive Provider Organization Plan).

Other Benefit Exclusions

- Stress reduction therapy or cognitive behavior therapy for sleep disorders.
- Sleep therapy (except for central or obstructive apnea when medically necessary and when a precertification has been received from the UM company), behavioral training or therapy, milieu therapy, biofeedback (unless included with psychotherapy), behavior modification, sensitivity training, hypnosis, electro hypnosis, electro-sleep therapy, electro-narcosis, massage therapy, and gene therapy.
- Charges that result from appetite control, food addictions, or any treatment of obesity, unless otherwise provided in the *Summary of Medical Benefits* and *Schedule of Medical Benefits.*
- Except as otherwise provided in the *Summary of Medical Benefits* and *Schedule of Medical Benefits*, drugs, medicines, procedures, services, and supplies to correct or enhance erectile function, enhance sensitivity or for sexual dysfunction (organic or inorganic), inadequacy,

or enhancement, including penile implants and prosthetics, injections, and durable medical equipment.

- Aroma therapy, massage therapy, reiki therapy, thermograph, orthomolecular therapy, contact reflex analysis, Bio-Energetic Synchronization Technique (BEST), colonic irrigation, magnetic innervation therapy and electromagnetic therapy.
- Natural and herbal remedies that may be purchased without a prescription (over the counter), through a web site, at a Physician or Chiropractor's office, or at a retail location are excluded, unless otherwise specified in the *Summary of Medical Benefits and Schedule of Medical Benefits.*

Medical Claims Administration

How Medical Benefits are Paid

Plan benefits are considered for payment on the receipt of written proof of claim, commonly called a bill. Generally, health care providers send their bill to PEBP's third-party claims administrator directly. Plan benefits for eligible services performed by health care providers will then be paid directly to the provider delivering the services. When Deductibles, Coinsurance or copayments apply, you are responsible for paying your share of these charges.

If services are provided through the EPO network, the EPO health care provider may submit the proof of claim directly to PEBP's third-party claims administrator; however, you will be responsible for the payment to the EPO health care provider for any applicable Deductible, Coinsurance, or copayments.

If a health care provider does not submit a claim directly to PEBP's third-party claims administrator and instead sends the bill to you, you should follow the steps outlined in this section regarding How to File a Claim. If, at the time you submit your claim, you furnish evidence acceptable to the Plan administrator or its designee (PEBP's third-party claims administrator) that you or your covered dependent paid some or all those charges, Plan benefits may be paid to you, but only up to the amount allowed by the Plan for those services after Plan Year Deductible and Coinsurance amounts are met.

How to File a Medical Claim

All claims must be submitted to the Plan within 12 months from the date of service. No Plan benefits will be paid for any claim submitted after this period. Benefits are based on the Plan's provisions in place on the date of service.

See also, NAC 287.610.

Most providers send their bills directly to the PEBP's claims administrator; however, for providers who do not bill the Plan directly, you may be sent a bill. In that case, follow these steps:

- Obtain a claim form from PEBP's third-party claims administrator or PEBP's website (see the *Participant Contact Guide* in this document for details on address, phone, and website).
- Complete the participant part of the claim form in full. Answer every question, even if the answer is "none" or "not applicable (N/A)."
- The instructions on the claim form will tell you what documents or medical information is necessary to support the claim. Your physician, health care practitioner or dentist can complete the health care provider part of the claim form, or you can attach the itemized bill for professional services if it contains all the following information:
- A description of the services or supplies provided including appropriate procedure codes.

- Details of the charges for those services or supplies.
- Appropriate diagnosis code.
- Date(s) the services or supplies were provided.
- Patient's name.
- Provider's name, address, phone number, and professional degree or license.
- Provider's federal tax identification number (TIN).
- Provider's signature.

Please review your bills to be sure they are appropriate and correct. Report any discrepancies in billing to the Claims Administrator. This can reduce costs to you and the Plan. Complete a separate claim form for each person for whom Plan benefits are being requested. If another plan is the primary payer, send a copy of the other plan's Explanation of Benefits (EOB) along with the claim you submit to this Plan.

To assure that medical, pharmacy or dental expenses you incur are eligible under this Plan, the Plan has the right to request additional information from any hospital, facility, physician, laboratory, radiologist, dentist, pharmacy or any other eligible medical or dental provider. For example, the Plan has the right to deny Deductible and Out-of-Pocket Maximum credit or payment to a provider if the provider's bill does not include or is missing one or more of the following components. This is not an all-inclusive list:

- Itemized bill to include but not be limited to: Proper billing codes such as CPT, HCPCS, Revenue Codes, CDT, ICD 9, and ICD 10.
- Date(s) of service.
- Place of service.
- Provider's Tax Identification Number.
- Provider's signature.
- Operative report.
- Patient ledger.
- Emergency room notes.
- Providers such as hospitals and facilities that bill for single or bulk items such as orthopedic devices/implants or other types of biomaterials shall provide to the third-party claim's administrator a copy of the manufacturer's/organization's invoice (that directly supplied the device/implant/biomaterial to the healthcare provider). This Plan will deny payment for such medical devices until a copy of the invoice is provided to this Plan's Claims Administrator.

Claims are processed by the third-party claims administrator in the order they are received.

It is your responsibility to maintain copies of the EOB documents provided to you by PEBP's third-party claims administrator or prescription drug administrator. Copies of EOB documents are available on the Claims Administrator's website but cannot be reproduced. PEBP and its third-party claims administrator do not provide printed copies of EOB documents outside of the original mailing.

Where to Send the Claim Form

Send the completed claim form, the bill you received (retain a copy for your records) and any other required information to the Claims Administrator at the address listed in the *Participant Contact Guide* in this document.

Appeals

You have the right to ask PEBP or its designees to reconsider a claim or Utilization Management Adverse Benefit Determination resulting in a denial, reduction, termination, failure to provide or make payments (in whole or in part) for a service or treatment, Rescission of coverage (retroactive cancellation), or HRA claim.

Discretionary Authority of PEBP and Designee

In carrying out their respective responsibilities under the Plan, PEBP and its designees have discretionary authority to interpret the terms of the Plan and to determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination made under that discretionary authority would be given full force and effect unless it can be shown that the interpretation or determination was arbitrary and capricious. Services that are covered, as well as specific Plan exclusions are described in this document.

Medical and Dental Claims Appeals

Written Notice of Adverse Benefit Determination

The Plan or its designee, the third-party administrator, will notify you in writing on an Explanation of Benefits (EOB) of an Adverse Claim Determination resulting in a denial, reduction, termination, or failure to provide or make payments (in whole or in part) of a benefit. The notice will explain the reasons why, with reference to the Plan provisions as to the basis for the adverse determination and it will explain what steps to take to submit a Level 1 Claim Appeal. When applicable, the notice will explain what additional information is required from you and why it is needed. A participant or their designee cannot circumvent the claims and appeals procedures by initiating a cause of action against the PEBP (or the State of Nevada) in a court proceeding.

You will be provided with:

(a) upon request and without charge, reasonable access to and copies of all relevant documents, records, and other information relevant to your claim for benefits;

(b) the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;

(c) a full and fair review that takes into account all comments, documents, records and other information submitted by you, without regard to whether such information was submitted or considered in the initial benefit determination;

(d) automatically and free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the denied claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date.

Additionally, before the Plan issues an Adverse Benefit Determination on review based on a new or additional rationale, you will be provided, automatically and free of charge, with the rationale.

The rationale will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you reasonable time to respond prior to that date.

If the Plan receives new or additional evidence or rationale so late in the claim filing or claim appeal process that a claimant would not have a reasonable opportunity to respond, the period for providing a final determination is delayed until such time as the claimant has had such an opportunity.

Level 1 Claim Appeal

NAC 287.670
If your claim is denied, or if you disagree with the amount paid on a claim, you may request a Level 1 Claim Appeal from the third-party administrator within 180 days of the date you received the Explanation of Benefits (EOB) which provides the claim determination. Failure to request a Level 1 Claim Appeal in a timely manner will be deemed to be a waiver of any further right of review of appeal under the Plan, unless good cause can be demonstrated. The written request for appeal must include:

- The name and Social Security Number, or identification number of the participant.
- A copy of the EOB related to the claim being appealed; and
- A detailed written explanation why the claim is being appealed.

You have the right to review documents applicable to the denial and to submit your own comments in writing. The third-party administrator will review your claim (by a person at a higher level of management than the one who originally denied the claim). If any additional information is needed to process your request for appeal, it will be requested promptly.

The third-party administrator will issue a decision of your Level 1 Claim Appeal in writing within 20 days after receipt of your request for appeal.

You will receive a notice of the appeal determination. If that determination is adverse, it will include at each level of the appeal review, the following:

(a) information that is sufficient to identify the claim involved (e.g., date of service, health care provider, claim amount if applicable);
(b) the statement that, upon request and free of charge, the diagnosis code and/or treatment code, and their corresponding meanings, will be provided. However, a request for this information will not be treated as a request for a 2nd level of appeal or external review (when external review is applicable);
(c) the specific reason(s) for the adverse appeal review decision, including the denial code and its corresponding meaning and a discussion of the decision, as well as any Plan standards used in denying the claim;
(d) reference the specific Plan provision(s) on which the determination is based;
(e) a statement that you are entitled to receive upon request, free access to and copies of documents relevant to your claim;

(f) an explanation of the Plan's appeal process and Level 2 appeal process and the external review process (when external review is applicable), along with any time limits and information regarding how to initiate the next level of review, as well as a statement of the voluntary Plan appeal procedures, if any;
(g) if the denial was based on an internal rule, guideline, protocol or similar criterion, a statement will be provided that such rule, guideline, protocol, or criteria that was relied upon will be provided free of charge to you, upon request;
(h) if the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request;
(i) the statement that "You and your Plan may have other voluntary dispute resolution options such as mediation. One way to find out what may be available is to contact your local U. S. Department of Labor Office and your State insurance regulatory agency;" and

disclosure of the availability of, and contact information for, any applicable health insurance consumer assistance or ombudsman established under the Public Health Services Act to assist individuals with internal claims and appeals and external review processes (when external review is applicable).

The notification will explain the steps necessary if you wish to proceed to a Level 2 Appeal if you are not satisfied with the response at Level 1.

Level 2 Claim Appeal

NAC 287.680
If you are unsatisfied with the Level 1 Claim Appeal decision made by the third-party administrator, you may file a Level 2 Claim Appeal to the PEBP Executive Officer or designee by completing a Claim Appeal Request form. *Claim Appeal Request form*s are available at www.pebp.state.nv.us or by request by contacting PEBP Customer Service. A Level 2 Appeal must be submitted to PEBP within 35 days after you receive the Level 1 Appeal determination. Your Level 2 Appeal **must** include a copy of:

- Any document submitted with your Level 1 Appeal request.
- A copy of the Level 1 Appeal decision; and
- Any documentation to support your request.

The Executive Officer or designee will use all resources available to assure a thorough review is completed in accordance with provisions of the Plan.

A Level 2 Appeal decision will be given to you in writing by certified mail within 30 days after the Level 2 Appeal request is received by the Executive Officer or designee. A Level 2 Appeal determination will explain and reference the reasons for the decision, including the applicable provisions of the Plan upon which the determination is based.

External Claim Review

NAC 287.690

Standard Request

An External Claim Review may be requested by a participant and/or the participant's treating physician after exhausting the Level 1 and Level 2 Claim Appeals process. This means that you may have a right to have the Plan's or its designee's decision reviewed by independent health care professionals if the adverse benefit determination involved making a judgment as to the medical necessity, appropriateness, health care setting, level of care or effectiveness of the health care setting or treatment you requested.

An External Claim Review request must be submitted in writing to the Office for Consumer Health Assistance (OCHA) within four (4) months after the date of receipt of a notice of the Level 2 Claim Appeal decision. An *External Review Request Form* is available on the PEBP website at www.pebp.state.nv.us. The OCHA will assign an independent external review organization within five 5 days after receiving the request. The external review organization will issue a determination within 15 days after it receives the complete information. For standard Request for External Claim Review, a decision will be made within 45 days of receiving the request.

A Request for External Claim Review must include:

- completed and signed External Review Request Form.
- a copy of the EOB(s) related to the claim(s) being reviewed.
- a detailed written explanation why the external review is being requested; and
- any additional supporting documentation.

The Request for External Claim Review must be submitted to:

Office for Consumer Health Assistance
3320 W. Sahara Avenue, Suite 100
Las Vegas NV 89102
Phone: (702) 486-3587,
(888) 333-1597
Fax 702-486-3586
Web: *http://dhhs.nv.gov/Programs/CHA/*

Appealing a Utilization Management Determination

The utilization management (UM) company is staffed with licensed health care professionals, who utilize nationally recognized health care screening criteria along with the medical judgment of their licensed health care professional, operating under a contract with the Plan to administer utilization review services. The review includes a process to determine the medical necessity, appropriateness, location, and cost effectiveness of health care services. Depending on the service, a review may occur before, during, or after the services are rendered, including, but not limited to precertification/pre-authorization; concurrent and/or continued stay review; discharge planning; retrospective review; and case management.

Pursuant to applicable NRS 695G, you have the following appeal processes for any adverse benefit determination made during the precertification, concurrent review, retrospective review, or case management. An appeal may be initiated by the participant, treating provider, parent, legal guardian, or person authorized to make health care decisions by a power of attorney.

The UM company will utilize a physician (other than the physician who rendered the original decision) to review the appeal. This physician is Board Certified in the area under review and is in active practice. Refer to the *Participant Contact Guide* for the UM company's contact information.

Internal UM Appeal Review

Expedited Internal UM Appeal Review

You may request an expedited appeal review of a denied precertification of a hospital admission, availability of care, continued stay or health care service for which you received emergency services but have not been discharged from the facility providing the care; or if the physician certifies that failure to proceed in an expedited manner may jeopardize your life or health or the life or health of your covered dependent or the ability for you or your covered dependent to regain maximum function.

Requests for an expedited internal UM appeal review may be made by telephone or any other reasonable means to the UM company that will ensure the timely receipt of the information required to complete the appeal process. If your physician requests a consultation with the reviewing physician, this will occur within one business day. The UM company will decide on an expedited appeal within 72 hours of receipt of the information needed to complete the appeal. The results of the determination of an expedited appeal will be provided immediately to the managing physician by phone and in writing to the patient, managing physician, facility, and the third-party claim's administrator.

If the appeal review request is denied, the UM company will provide the member with an adverse benefit determination letter including the clinical rationale for the non-certification decision and the member may pursue an external appeal as described in NRS 695G.241 - NRS 695G.275.

Standard Internal UM Appeal Review

If you have a denied precertification request (or a denial/non-certification at any other level of UM review such as concurrent review, retrospective review, or case management issue) and you do not qualify for an expedited appeal, you may request a standard appeal review. Requests for standard appeal review may be made by writing to the UM company.

Requests for standard appeal review must be made within 180 days of the date of the denial/non-certification. Actual medical records are encouraged to be provided to assist the reviewer. Standard appeals for pre-service denials will be reviewed by a physician within 15 days of the UM company's receipt of the request. Appeals for post-service treatment will be completed within 20 days of the receipt of the request. The results of the determination of a standard appeal will be provided in writing to the patient, managing physician, facility, and third-party claim's administrator.

A participant or their designee can choose to bypass the internal appeals process from adverse benefit determinations resulting from the UM company and request a review by an external review organization.

External UM Appeal Review

An external review may be requested by a participant and/or the participant's treating physician after you have exhausted the internal UM appeal review process. This means you may have the right to have the Plan Administrator or its designee's decision reviewed by independent health care professionals if the adverse benefit determination involved making a judgement as to the medical necessity, appropriateness, health care setting, level of care or effectiveness of the health care setting or treatment you requested.

Expedited Request for External Review (Pre-Service Urgent UM Appeal)

NRS 287.04335

For adverse benefit determinations resulting from the UM company, a participant or their designee can choose to bypass the internal UM appeal process and request a review by an external review organization.

Expedited external review is available only if the request is filed within four (4) months after the date of receipt of a notice of an adverse benefit determination and the patient's treating provider certifies that adherence to the time frame for the standard external review would seriously jeopardize the life or health of the covered individual or would jeopardize the covered individual's ability to regain maximum function. Pursuant to NRS 695G.271, the Office for Consumer Health Assistance (OCHA) will approve or deny a request for an external review of an adverse determination not later than 72 hours after receipt from the provider. If OCHA determines the request qualifies for expedited review, a final of the external review will made by the external review organization within 72 hours of receipt and the provider and participant will be notified within 24 hours.

A participant may file a request for an expedited external review with the Office for Consumer Health Assistance (OCHA) if the request is filed within four (4) months after the date of receipt of a notice of an adverse benefit determination or final internal adverse benefit determination. An expedited external review request form, which includes a certification of treating provider for expedited consideration can be found on the PEBP website at www.pebp.state.nv.us.

The request must be submitted to:

Office for Consumer Health Assistance
3320 W. Sahara Avenue, Suite 100
Las Vegas NV 89102
Phone: (702) 486-3587,
(888) 333-1597
Fax 702-486-3586
Web: *http://dhhs.nv.gov/Programs/CHA/*

Standard Request for External UM Review

A standard request for external UM review may be filed with the Office for Consumer Health Assistance (OCHA) if the request is filed within four (4) months after the date of receipt of a notice of an adverse benefit determination or final internal adverse benefit determination. A standard external review request form can be found on the PEBP website at www.pebp.state.nv.us.

A standard external review decision will be made within 45 days of OCHA's receipt of the request.

As with the expedited external review, a standard external review must be submitted to the Office for Consumer Health Assistance at the contact information listed above.

Experimental and/or Investigational Claim/UM External Review

If you received a denial for a service, durable medical equipment, procedure, or other therapy because the third-party administrator or the UM company determined it to be experimental and/or investigational, you may request an external review. To proceed with the experimental and/or investigational external review, you must obtain a certification from the treating physician indicating that the treatment would be significantly less effective if not received.

A "Physician Certification of Experimental/Investigational /Denials" is located under "Forms" on the PEBP website at www.pebp.state.nv.us.

After this form is completed by the treating physician, it should be attached to the Request for External Review" form and submitted to the Office for Consumer Health Assistance at:

Office for Consumer Health Assistance
3320 W. Sahara Avenue, Suite 100
Las Vegas NV 89102
Phone: (702) 486-3587,
(888) 333-1597
Fax 702-486-3586
Web: *http://dhhs.nv.gov/Programs/CHA/*

Prescription Drug Review and Appeals

A participant has the right to request that a medication be covered or be covered at a higher benefit (e.g., lower copay, higher quantity, etc.). The first request for coverage is called an initial coverage review. The Pharmacy Benefit Manager reviews both clinical and administrative coverage review requests, including those cases related to specialty drugs dispensed through Accredo specialty pharmacy.

Clinical Coverage Review

The initial clinical coverage review is a request for coverage or medication that is based on clinical conditions of coverage that are set by this Plan—for example, medications that require a prior authorization. To make an initial determination for a clinical coverage review request, the prescribing physician must submit specific information for review.

How to Request a Clinical Coverage Review

The preferred method to request an initial clinical review is for the prescribing physician to submit the prior authorization request electronically. Alternately, the participant's prescribing physician or pharmacist may call Express Scripts at 1-800-753-2851 or the prescriber may submit a request in writing using a Benefit Coverage Review Form, which can be obtained by calling Express Scripts Member Services at 1-855-889-7708~~1-855-889-7708 or the prescriber may submit a completed Initial Coverage Review form obtained online at www.express-scripts.com/services/physicians/~~. (Home delivery coverage review requests are automatically initiated by the home delivery pharmacy as part of filling the prescription.)

Administrative Coverage Review

The initial administrative coverage review is a request for coverage of a medication that is based on the Plan's benefit design.

How to Request an Administrative Coverage Review

To request an initial administrative coverage review, the participant must submit the request in writing to Express Scripts to the attention of the Benefit Coverage Review Department (see *Participant Contact Guide* section).

For an administrative coverage review request, the participant must submit information to the pharmacy benefits manager to support the request.

If the patient's situation meets the definition of urgent under the law, an urgent review may be requested and conducted as soon as possible, but no later than 72 hours from receipt of request. In general, an urgent situation is one which, in the opinion of the attending provider, the patient's health may be in serious jeopardy, or the patient may experience pain that cannot be adequately controlled while the patient waits for a decision on the review. If the patient or provider believes the patient's situation is urgent, the expedited review must be requested by calling Express Scripts at 1-800-753-2851.

If the necessary information is provided to Express Scripts so that a determination can be made, the initial determination and notification for a clinical coverage or administrative coverage review will be made within the timeframe below:

- Standard Pre-Service: 15 days for retail pharmacy and five (5) days for home delivery; and
- Standard Post-Service: 30 days.

Level 1 Appeal or Urgent Appeal

When an initial administrative or clinical coverage review request has been denied, a request for appeal of the denial may be submitted by the participant within 180 days from receipt of notice of the initial adverse benefit determination. To initiate an appeal, the following information must be submitted by mail or fax to Express Scripts' Benefit Coverage Review Department:

- Name of patient.
- Participant ID number.

- Phone number.
- The drug name for which benefit coverage has been denied.
- Brief description of why the claimant disagrees with the initial adverse benefit determination; and
- Any additional information that may be relevant to the appeal, including physician/prescriber statements/letters, bills, or any other documents.

An urgent appeal may be submitted if in the opinion of the attending provider, the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function or would subject the patient to sever pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Urgent appeals must be submitted by phone at 1-800-753-2851 or fax 1-877-852-4070 to Express Scripts. Appeals submitted by mail will not be considered urgent processing unless a subsequent phone call or fax identifies the appeal as urgent.

Express Scripts completes appeals per business policies that are aligned with state and federal regulations. Depending on the type of appeal, appeal decisions are by Express Scripts' pharmacist, physician, panel of clinicians, trained prior authorization staff member, or an independent third-party prescription drug utilization management company.

Level 1 Appeal Decisions and Notifications

Express Scripts will render Level 1 Appeal determinations within the following timeframes:

- Standard pre-service: 15 days.
- Standard post-service: 20 days; and
- Urgent*: 72 hours.

If new information is received and considered or relied upon in the review of the appeal, such information will be provided to the patient and prescriber together with an opportunity to respond prior to issuance of any final adverse benefit determination. Standard Post-Service: NAC 287.670

Level 2 Appeal

When a Level 1 Appeal has been denied, a request for a Level 2 Appeal may be submitted by the participant within 35 days from receipt of notice of the Level 1 Appeal denial. To initiate a Level 2 Appeal, you must request by mail or fax to the appropriate Clinical Coverage or Administrative Coverage Review Request department.

An urgent Level 2 Appeal may be submitted if in the opinion of the attending provider, the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function or

would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Urgent appeals must be submitted by phone or fax to the appropriate Clinical Coverage or Administrative Coverage Review Request department (see the *Participant Contact Guide* section). Claims and appeals submitted by mail will not be considered for urgent processing unless a subsequent phone call or fax identifies the appeal as urgent.

Level 2 Appeal Decisions and Notifications

Express Scripts will render Level 2 Appeal determinations within the following timeframes:

- Standard pre-service: 15 days.
- Standard post-service: 30 days; and
- Urgent*: 72 hours.

If new information is received and considered or relied upon in the review of the appeal, such information will be provided to the patient and prescriber together with an opportunity to respond prior to issuance of any final adverse determination. Standard Post-Service: NAC 287.680

External Reviews

The right to request an independent external review may be available for an adverse benefit determination involving medical judgement, rescission, or a decision based on medical information, including determinations involving treatment that is considered experimental and investigation. Generally, all internal appeal rights must be exhausted prior to requesting an external review. The external review will be conducted by an independent review organization with medical experts that were not involved in the prior determination of the claim.

To submit an external review, the request must be mailed or faxed to the independent review organization (see *Participant Contact Guide*) within 4 (four) months of the date of the Level 2 Appeal denial. (If the date that is 4 (four) months from that date is a Saturday, Sunday, or a holiday, the deadline will be the next business day).

Standard External Review: the pharmacy benefit manager will review the external review request within 5 (five) business days to determine if it is eligible to be forwarded to an independent review organization (IRO) and the patient will be notified within 1 (one) business day of the decision.

If the request is eligible to be forwarded to an IRO, the request will randomly be assigned to an IRO, and the Appeal information will be compiled and sent to the IRO within 5 (five) business days of assigning the IRO. The IRO will notify the claimant in writing that it has received the request for an external review and if the IRO has determined that the claim involves medical judgement or rescission, the letter will describe the claimant's right to submit additional information within 10 business days for consideration to the IRO. Any additional information the claimant submits to the IRO will also be sent back to the pharmacy benefit manager for

reconsideration. The IRO will review the claim within 45 calendar days from receipt of the request and will send the claimant, the Plan and the pharmacy benefit manager written notice of its decision. If the IRO has determined that the claim does not involve medical judgement or rescission, the IRO will notify the claimant in writing that the claim is ineligible for a full external review.

Urgent External Review

Once an urgent external review request is submitted, the claim will immediately be reviewed to determine if it is eligible for an urgent external review. An urgent situation is one where in the opinion of the attending provider, the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health or the ability for the patient to regarding maximum function or would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

If the claim is eligible for urgent processing, the claim will immediately be reviewed to determine if the request is eligible to be forwarded to an IRO, and the claimant will be notified of the decision. If the request is eligible to be forwarded to an IRO, the request will randomly be assigned to an IRO and the Appeal information will be compiled and sent to the IRO. The IRO will review the claim within 72 hours from receipt of the request and will send the claimant written notice of its decision

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Coordination of Benefits

For information, refer to the separate PEBP Health and Welfare Wrap Document available at www.pebp.state.nv.us under “4.4 Coordination of Benefits” (NAC 287.755).

Subrogation and Third-Party Recovery

Subrogation applies to situations where the Participant is injured, and another person or entity is or may be responsible, liable, or contractually obligated, for whatever reason, for the payment of certain damages or claims arising from or related in any way to the Participant's injury (the "Injury"). These damages or claims arising from the injury, irrespective of the way they are categorized, may include, without limitation, medical expenses, pain and suffering, loss of consortium, and/or wrongful death. The Plan has a right of subrogation irrespective of whether the damages or claims are paid or payable to the Participant, the Participant's estate, the Participant's survivors, or the Participant's attorney(s). All payments made by the Plan for which it claims a right of subrogation are referred to as subrogated payments.

The subrogation provision provides the Plan with a right of recovery for certain payments made by the Plan, irrespective of fault, or negligence wrongdoing. All payments made by the Plan relating in any way to the injury may be recovered directly from the other person or from any judgment, verdict or settlement obtained by the participant in relation to the injury.

The Participant must cooperate fully, always, and provide all information needed or requested by the Plan to recover payments, execute any papers necessary for such recovery, and do whatever is necessary or requested to secure and protect the subrogation rights of the Plan. The Participant's required cooperation includes, but is not limited to, the following actions, which must be performed immediately, upon request by the Plan:

(1) Executing an acknowledgment form or other document acknowledging and agreeing to protect the Plan's right of subrogation.
(2) Cooperating and participating in the Plan's recovery efforts, including but not limited to participating in litigation commenced or pursued by the Plan or its Board; and
(3) Filing a claim or demand with another insurance company, including but not limited to the Participant's own first party insurance policy or another person's or entity's insurance policy.

Refer to the separate *Health and Welfare Benefits Wrap Plan* document available at www.pebp.state.nv.us for more information regarding third-party liability and subrogation.

Participant Contact Guide

Participant Contact Guide	
Public Employees' Benefits Program (PEBP) **901 S. Stewart Street, Suite 1001** **Carson City, NV 89701** **Customer Service:** **(775) 684-7000, (702) 486-3100, or (800) 326-5496** **Fax: (775) 684-7028** **www.pebp.state.nv.us**	**Plan Administrator** • Enrollment and eligibility • COBRA information and premium payments • Level 2 claim appeals • External review coordination
UMR **Claims Submission** **P O Box 30541** **Salt Lake City, UT 84130-0541** **EDI #39026** **Appeal of Claims** **P O Box 30546** **Salt Lake City, UT 84130-0546** **Customer Service: (888) 763-8232** **www.UMR.com** **Diabetes Care Management form submission** **UMR** **27 Corporate Hill Drive** **Little Rock, AR 77205 Fax: 800-458-0701** **Email: diabetes@HealthscopeBenefits.com**	**Third-party Claims Administrator/Third-party Administrator/PPO Network/Disease Management Administrator for Diabetes** • Claim submission • Claim status inquiries • Level 1 claim appeals • Verification of eligibility • Plan Benefit Information • CDHP & Dental only ID Cards • Obesity Care Management Program • Disease Care Management Program • Sierra Health-Care Options (SHO) – Southern Nevada PPO Network • UnitedHealthcare Choice Plus – Outside of Southern Nevada PPO Network • Behavioral Health-Care Options (BHO) – Behavioral Health Network in Nevada
Utilization Management Company **Sierra Health-Care Options, Inc** **PO BOX 15645** **Las Vegas, NV 89144-5648** **Customer Service : 888-323-1461** **Fax : 800-282-8845**	• Pre Certification/Prior Authorization • Utilization Management • Case Management • Transplants

Express Scripts Pharmacy Benefit Administrator
Customer Service and Prior Authorization
(855) 889-7708
www.Express-Scripts.com

Accredo Patient Customer Service
(800) 803-2523

Accredo Physician Service Line
(800) 987-4904 option 5

Express Scripts / Accredo Prior Authorization
(800) 753-2851
Electronic options: express-scripts.com/PA

Specialty Medication SaveOnSP copay assistance
(800) 683-1074
www.saveonsp.com/pebp

~~Express Scripts Pharmacy Benefit Administrator~~
~~Customer Service and Prior Authorization~~
~~(855) 889-7708~~
~~www.Express-Scripts.com~~

~~Express Scripts Home Delivery/Accredo Specialty Drug Services~~
~~PO Box 66566~~
~~St. Louis, MO 63166-6566~~
~~Customer Service: (855) 889-7708~~

~~Express Scripts Benefit Coverage Review Department~~
~~PO Box 66587, St. Louis, MO 63166-6587~~
~~Phone: 800-946-3979~~
~~Administrative Coverage Review and Appeals~~

~~SaveonSP~~
~~1-800-683-1074~~

Pharmacy Benefit Manager for the CDHP
Prescription drug information

- Retail network pharmacies
- Prior authorization
- Customer service
- Formulary, forms, online ordering
- Price a Medication tool
- Home delivery service and Mail Order forms
- Preferred Mail Order for diabetic supplies

Express Scripts Clinical Appeals Department
PO Box 66588 St. Louis, MO 63166-6588
Phone: 800-753-2851
Fax: 877-852-4070

- Clinical Reviews

MCMC LLC Attn: Express Scripts Appeal Program
300 Crown Colony Dr. Suite 203
Quincy, MA 02169-0929
Phone: 617-375-7700 ext. 28253
Fax: 617-375-7683
External Review Requests

Diversified Dental Services **5470 Kietzke Lane, Ste 300** **Reno, NV 89511** **ProviderRelations@ddsppo.com** **1-866-270-8326** **diversifieddental.com**	PPO Dental Network • Statewide PPO Dental Providers • Dental Provider directory • National PPO Dental Providers outside of Nevada utilizes the Principal Dental Network
United Healthcare **Group Number: 370074** **Customer Service: 1-888-763-8232** **UnitedHealthcare Specialty Benefits** **P.O. Box 7149** **Portland, ME 04112-7149**	• Basic Life Insurance for eligible active and retirees
The Standard Insurance Company **900 SW Fifth AvenuePortland, OR 97204** **(888) 288-1270** ***https://www.standard.com/mybenefits/nevada/***	• Voluntary (Supplemental) Life Insurance • Long-Term Disability • Voluntary Short-Term Disability • Generali Travel Assistance • Beneficiary Designations
Office for Consumer Health Assistance **555 E. Washington Avenue, Suite 4800** **Las Vegas, NV 89101** **Customer Service:** **(702) 486-3587 or (888) 333-1597** ***http://dhhs.nv.gov/Programs/CHA/Contact_GovCHA/***	• Consumer Health Assistance • Concerns and problems related to coverage • Provider billing issues • External review information

Key Terms and Definitions

The following terms or phrases are used throughout this MPD. These terms or phrases have the following meanings. These terms and definitions do not, and should not be interpreted to, extend coverage under the Plan.

Accident: A sudden and unforeseen event that is not work-related, resulting from an external or extrinsic source.

Active Rehabilitation: refers to therapy in which a patient, who can learn and remember, actively participates in the rehabilitation that is intended to provide significant and measurable improvement of an individual who is restricted and cannot perform normal bodily function.

Actively Engaged:

- Participation in regular office visits with your provider. The frequency of the office visits will be determined by your provider who will in turn report this information to the third-party administrator for monitoring.
- Consistently demonstrating a commitment to weight loss by adhering to the weight loss treatment plan developed by your weight loss provider including but not limited to routine exercise, proper nutrition and diet, and pharmacotherapy if prescribed. Commitment to your weight loss treatment will be measured by the third-party administrator who will review monthly progress reports submitted by the provider; and
- Losing weight at a rate determined by the weight loss provider.

Activities of Daily Living: Activities performed as part of a person's daily routine, such as getting in and out of bed, bathing, dressing, feeding, or eating, use of the toilet, ambulating, and taking drugs or medicines that can be self-administered.

Acupuncture: A technique for treating disorders of the body by passing long thin needles through the skin. This technique is based on the belief that physical illness and disorders are caused by imbalances in the life force, called Qi, which flows through the body along meridians or channels, and that the needles stimulate the natural healing energy flow.

When benefits for the services of an acupuncturist are payable by this Plan, the acupuncturist must be properly licensed by the state in which he or she is practicing and must be performing services within the scope of that license, or, where licensing is not required, be certified by the National Certification Commission for Acupuncturists (NCCA).

Adverse Benefit Determination: NRS 695G.0–2 - Means a determination by a health carrier or utilization review organization that an admission, availability of care, continued stay or other health care service that is a covered benefit has been reviewed and, based upon the information provided, does not meet the health carrier's requirements for medical necessity,

appropriateness, health care setting, level of care or effectiveness, and the requested service or payment for the service is therefore denied, reduced or terminated.

Air Ambulance: A medical transport by a rotary wing air ambulance, as defined in 42 CFR 414.605, or fixed wing air ambulance, as defined in 42 CFR 414.605, for patients.

Allogenic: Refers to transplants of organs, tissues, or cells from one person to another person. Heart Transplants are always Allogenic.

Allowable Expenses: The Maximum Allowable Charge for any medically necessary, eligible item of expense, at least a portion of which is covered under the Plan. When some other non-Medicare plan pays first in accordance with the application to benefit determinations provision in the *Coordination of Benefits* section, this Plan's allowable expenses shall in no event exceed the other non-Medicare plan's allowable expenses.

When some other non-Medicare plan provides benefits in the form of services rather than cash payments, the Plan Administrator shall assess the value of each service rendered, by determining the amount that would be payable in accordance with the terms of the Plan, shall be deemed to be the benefit. Benefits payable under any other non-Medicare plan include the benefits that would have been payable had claim been duly made; therefore, whether or not it is made.

Ambulance: A vehicle or boat that is licensed or certified for emergency patient transportation by the jurisdiction in which it operates.

Ambulatory Surgical Facility/Center: A specialized facility that is established, equipped, operated, and staffed primarily for performing surgical procedures and which fully meets one of the following two tests:

- It is licensed as an ambulatory surgical facility/center by the regulatory authority responsible for the licensing under the laws of the jurisdiction in which it is located; or

Where licensing is not required, it meets all the following requirements:

- It is operated under the supervision of a licensed physician who is devoting full time to supervision and permits a surgical procedure to be performed only by a duly qualified physician who, at the time the procedure is performed, is privileged to perform the procedure in at least one hospital in the area.
- It requires in all cases, except those requiring only local infiltration anesthetics, that a licensed anesthesiologist administer the anesthetic or supervise an anesthetist who is administering the anesthetic, and that the anesthesiologist or anesthetist remain present throughout the surgical procedure.
- It provides at least one operating room and at least one post-anesthesia recovery room.
- It is equipped to perform diagnostic x-ray and laboratory examinations or has an arrangement to obtain these services.

- It has trained personnel and necessary equipment to handle emergency situations.
- It has immediate access to a blood bank or blood supplies.
- It provides the full-time services of one or more registered graduate nurses (RNs) for patient care in the operating rooms and in the post-anesthesia recovery room; and
- It maintains an adequate medical record for each patient, which contains an admitting diagnosis (including, for all patients except those undergoing a procedure under local anesthesia, a preoperative examination report, medical history, and laboratory tests and/or x-rays), an operative report and a discharge summary.

An ambulatory surgical facility/center that is part of a hospital, as defined in this section, will be considered an ambulatory surgical facility/center for the purposes of this Plan.

Ancillary Services/Charges: Charges for services provided by a hospital or other facility other than room and board, including (but not limited to) use of the operating room, recovery room, intensive care unit, etc., and laboratory and x-ray services, drugs and medicines, and medical supplies provided during confinement.

Ancillary services: for purposes of the No Surprises Act, are with respect to a PPO health care facility:

- Items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a physician or non-physician practitioner,
- Items and services provided by assistant surgeons, hospitalists, and intensivists;
- Diagnostic services, including radiology and laboratory services and subject to exceptions specified by the Secretary of Department of Health and Human Services; and

Items and services provided by a Non-PPO provider if there is no PPO provider who can furnish such item or service at such facility.

Anesthesia: The condition produced by the administration of specific agents (anesthetics) to render the patient unconscious and without conscious pain response (e.g., general anesthesia), or to achieve the loss of conscious pain response and/or sensation in a specific location or area of the body (e.g., regional, or local anesthesia). Anesthetics are commonly administered by injection or inhalation.

Annual/Annually: For the purposes of this Plan, annual and annually refers to the 12-month period starting July 1 through June 30.

Appliance (Dental): A device to provide or restore function or provide a therapeutic (healing) effect.

Appropriate: See the definition of medically necessary for the definition of appropriate as it applies to medical services that are medically necessary.

Approved Clinical Trial: A phase I, II, III, or IV trial if it is conducted for the prevention, detection, or treatment of cancer or another disease or condition likely to lead to death unless the course of the disease or condition is interrupted.

An Approved Clinical Trial's study must be:

(1) approved or funded by one or more of:
- (a) the National Institutes of Health (NIH),
- (b) the Centers for Disease Control and Prevention (CDC),
- (c) the Agency for Health Care Research and Quality (AHCRQ),
- (d) the Centers for Medicare and Medicaid Services (CMS),
- (e) a cooperative group or center of the NIH, CDC, AHCRQ, CMS, the Department of Defense (DOD), or the Department of Veterans Affairs (VA),
- (f) a qualified non-governmental research entity identified by NIH guidelines for grants; or
- (g) the VA, DOD, or Department of Energy (DOE) if the study has been reviewed and approved through a system of peer review that the Secretary of HHS determines is comparable to the system used by NIH and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review;

(2) a study or trial conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA); or

(3) a drug trial that is exempt from investigational new drug application requirements.

Assistant Surgeon: A medically qualified doctor who assists the surgeon of record perform a procedure.

Autism Spectrum Disorders and related terms Have the meanings ascribed to them under NRS 695G.1645 and NRS 427A.875.

Autologous: Refers to transplants of organs, tissues, or cells from one part of the body to another. Bone marrow and skin transplants are often autologous.

Average Wholesale Price (AWP): The average price at which drugs are purchased at the wholesale level.

Bariatric Surgery Center of Excellence: This provider has met the requirements outlined by the American College of Surgeons National Surgical Quality Improvement Program (ACS NSQIP) and is accredited by the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP). The accreditation of a Bariatric Surgery Center of Excellence helps identify providers with whom a participant should expect to receive safer and more effective surgical treatment. These MBSAQIP accredited providers adhere to a multidisciplinary surgical

preparatory regimen to include but not limited to the following:

- Behavior modification program supervised by a qualified professional.
- Consultation with a dietician or nutritionist.
- Documentation in the medical record of the participant's active participation and compliance with the multidisciplinary surgical preparatory regimen at each visit. A physician's summary letter, without evidence of concurrent oversight is not sufficient documentation. Documentation should include medical records of the physician's initial assessment of the participant, and the physician's assessment of the participant at the completion of the multidisciplinary surgical preparatory regimen.
- Exercise regimen (unless contraindicated) to improve pulmonary reserve prior to surgery, supervised by an exercise Therapist or other qualified professional.
- Program must have a substantial face-to-face component (must not be entirely delivered remotely); and
- Reduced-calorie diet program supervised by dietician or nutritionist.

Base Plan: The self-funded Consumer Driven Health Plan (CDHP); the base plan is also defined as the "default plan" where applicable in this document and other materials produced by PEBP (NRS 287.045).

Behavioral Health Disorder: Any illness that is defined within the mental disorders section of the current edition of the International Classification of Diseases (ICD) manual or is identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), including a psychological and/or physiological dependence on or addiction to alcohol or psychiatric drugs or medications regardless of any underlying physical or organic cause.

Behavioral health disorders covered under this Plan may include, but are not limited to depression, schizophrenia, and substance abuse and treatment that primarily uses psychotherapy or other psychotherapist methods and is provided by behavioral health practitioners as defined in this section. Certain behavioral health disorders, conditions and diseases are specifically excluded from coverage as noted in the *Exclusions* section.

Behavioral Health Practitioner: A psychiatrist, psychologist, or a mental health or substance abuse counselor or social worker who has a master's degree and who is legally licensed and/or legally authorized to practice or provide service, care, or treatment of behavioral health disorders under the laws of the state or jurisdiction where the services are rendered; and acts within the scope of his or her license.

Behavioral Health Treatment: Services, including room and board, given by a behavioral health treatment facility or area of a hospital that provides behavioral or mental health or substance abuse treatment for a mental disorder identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM). If there are multiple diagnoses, only the treatment for the illness that is identified under the DSM code is considered a behavioral health treatment for the purposes of this Plan.

Behavioral Health Treatment Facility: A specialized facility that is established, equipped, operated, and staffed primarily for providing a program for diagnosis, evaluation, and effective treatment of behavioral health disorders and which fully meets one of the following two tests:

- It is licensed as a behavioral health treatment facility by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located; or
- Where licensing is not required, it meets all the following requirements: has at least one physician on staff or on call and provides skilled nursing care by licensed nurses under the direction of a full-time registered nurse (RN) and prepares and maintains a written plan of treatment for each patient based on the medical, psychological, and social needs of the patient.

A behavioral health treatment facility that qualifies as a hospital is covered by this Plan as a hospital and not a behavioral health treatment facility. A transitional facility, group home, halfway house or temporary shelter is not a behavioral health treatment facility under this Plan unless it meets the requirements above in the definition of behavioral health treatment facility.

Benefit, Benefit Payment, Plan Benefit: The amount of money payable for a claim, based on the usual and customary charge, subject to the Plan's Maximum Allowable Charge, or negotiated fee schedule, after calculation of all Deductibles, Coinsurance, and copayments, and after determination of the Plan's exclusions, limitations, and maximums.

Birth (or Birthing) Center: A specialized facility that is primarily a place for delivery of children following a normal uncomplicated pregnancy and which fully meets one of the two following tests:

- It is licensed by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located; or
- Where licensing is not required, it meets all the following requirements:
- It is operated and equipped in accordance with any applicable state law for providing prenatal care, delivery, immediate post-partum care, and care of a child born at the center.
- It is equipped to perform routine diagnostic and laboratory examinations, including (but not limited) to hematocrit and urinalysis for glucose, protein, bacteria and specific gravity, and diagnostic x-rays, or has an arrangement to obtain those services.
- It has available to handle foreseeable emergencies, trained personnel, and necessary equipment, including (but not limited to) oxygen, positive pressure mask, suction, intravenous equipment, equipment for maintaining infant temperature and ventilation, and blood expanders.
- It provides at least two beds or two birthing rooms.
- It is operated under the full-time supervision of a licensed physician, registered nurse (RN) or certified nurse midwife.

- It has a written agreement with at least one hospital in the area for immediate acceptance of patients who develop complications.
- It has trained personnel and necessary equipment to handle emergency situations.
- It has immediate access to a blood bank or blood supplies.
- It has the capacity to administer local anesthetic and to perform minor surgery.
- It maintains an adequate medical record for each patient that contains prenatal history, prenatal examination, any laboratory or diagnostic tests and a post-partum summary.
- It is expected to discharge or transfer patients within 48 hours following delivery.

A birth (or birthing) center that is part of a hospital, as defined in this section, will be a birth (or birthing) center for the purposes of this Plan.

Business Day: Refers to all weekdays, except Saturday or Sunday, or a Nevada holiday or federal holiday.

Case Management: A process administered by the UM company in which its medical professionals work with the patient, family, caregivers, providers, Claims Administrator, Pharmacy Benefit Manager and PEBP to coordinate a timely and cost-effective treatment program. Case management services are particularly helpful when the patient needs complex, costly, and/or high-technology services, and when assistance is needed to guide patients through a maze of potential providers.

Cardiac Rehabilitation: Cardiac Rehabilitation refers to a formal program of controlled exercise training and cardiac education under the supervision of qualified medical personnel capable of treating cardiac emergencies, as provided in a hospital outpatient department or other outpatient setting. The goal is to advance the patient to a functional level of activity and exercise without cardiovascular complications to limit further cardiac damage and reduce the risk of death. Patients are to continue at home the exercise and educational techniques they learn in this program. Cardiac rehabilitation services are payable for patients who have had a heart attack (myocardial infarction) or open-heart surgery.

Certified Surgical Assistant: A person who does not hold a valid health care license as an RN, Nurse Practitioner (NP), Physician Assistant (PA), Podiatrist, Dentist, MD or DO, who assists the primary surgeon with a surgical procedure in the operating room and who bills, commonly as an assistant surgeon, and who acts within the scope of their license or certification. Such individuals are payable by this Plan, including but not limited to designation as a Certified Surgical Assistant (CSA), Certified Surgical Technologist (CST), Surgical Technologist (ST), Certified Technical Assistant (CTA), or Certified Operating Room Technician (CORT).

Chemical Dependency: This is another term for Substance Abuse. (See also the definitions of Behavioral Health Disorders and Substance Abuse).

Child(ren): See the definition of Dependent Child(ren).

Chiropractor: A person who holds the degree of Doctor of Chiropractic (DC) and is legally licensed and authorized to practice the detection and correction, by mechanical means, of the interference with nerve transmissions and expressions resulting from distortion, misalignment, or dislocation of the spinal column (vertebrae); and who acts within the scope of his or her license.

Chiropractic Services: PEBP considers chiropractic services to be medically necessary when all the following criteria are met:

- participant has objective medical findings of a neuro-musculoskeletal disorder; and
- a clearly defined treatment plan has been established including treatment and discharge goals; and
- services are not for maintenance purposes.

Christian Science Practitioner: Christian Science is a system of religious teaching based on an interpretation of scripture, founded in 1866 by Mary Baker Eddy. It emphasizes full healing of disease by mental and spiritual means. Certain members of the Christian Science church are designated as Christian Science Practitioners who counsel and assist church members in mental and spiritual means to overcome illness based on Christian Science teachings.

Chronic Medication Synchronization: NRS 695G.1665 "Chronic medication" means any drug that is prescribed to treat any disease or other condition which is determined to be permanent, persistent, or lasting indefinitely.
"Synchronization" means the alignment of the dispensing of multiple medications by a single contracted pharmacy for improving a patient's adherence to a prescribed course of medication. This includes providing coverage for less than a 30-day supply to enable synchronization. See also NRS 695G.1665)

Claims Administrator: The person or company retained by the Plan to administer claim payment responsibilities and other administration or accounting services as specified by the Plan.

Clinical Trials: See ***Experimental and Investigational*** in the *Key Terms and Definitions* section.

Coinsurance: That portion of *Eligible Medical Expenses* for which the covered person has financial responsibility. In most instances, the covered individual is responsible for paying a percentage of covered medical expenses more than the Plan's Deductible. The Coinsurance varies depending on whether In-Network or Out-of-Network providers are used.

Complications of Pregnancy: Any condition that requires hospital confinement for medical treatment, and if the pregnancy is not terminated, is caused by an injury or sickness not directly related to the pregnancy or by acute nephritis, nephrosis, cardiac decompensation, missed abortion or similar medically diagnosed conditions; or, any condition that requires hospital

confinement and if the pregnancy is terminated, results in non-elective cesarean section, ectopic pregnancy or spontaneous termination.

Compound Drugs: Any drug that has more than one ingredient and at least one of them is a Federal Legend Drug or a drug that requires a prescription under state law.

Concierge Medicine: Is a relationship between a patient and a primary care physician or dentist in which the patient usually pays an annual or monthly fee or retainer to receive easier access to a primary care provider or dentist. Concierge medicine usually means that the patient will experience quicker scheduling of appointments, limited or no waiting times, longer and more thorough examinations and coordination of all medical or dental care. Other terms in use include boutique medicine, retainer-based medicine, and innovative medical practice design. The practice is also referred to as membership medicine, concierge health care, cash only practice, direct care, direct primary care, and direct practice medicine. Most concierge medicine practices do not bill insurance.

Concurrent Review: A managed care program designed to assure that hospitalization and health care facility admissions and length of stay, surgery and other health care services are medically necessary by having the utilization management company conduct ongoing assessment of the health care as it is being provided, especially (but not limited to) inpatient confinement in a hospital or health care facility.

Continuing Care Patient: Under the NSA, an individual who, with respect to a provider or facility-

1. is undergoing a course of treatment for a serious and complex condition from the provider or facility;
2. is undergoing a course of institutional or inpatient care from the provider or facility;
3. is scheduled to undergo non-elective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such a surgery;
4. is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or
5. is or was determined to be terminally ill (as determined under section 1861(dd)(3)(A) of the Social Security Act) and is receiving treatment for such illness from such provider or facility.

Convalescent Care Facility: See the definition of Skilled Nursing Facility.

Coordination of Benefits (COB): The rules and procedures applicable to the determination of how Plan benefits are payable when a person is covered by two or more health care plans.

Copayment, Copay: The fixed dollar amount you are responsible for paying when you incur an eligible medical expense for certain services, generally those provided by network health care practitioners, hospitals (or emergency rooms of hospitals), or health care facilities. This can be in

addition to Coinsurance amounts due on the same incurred charges. Copayments are limited to certain benefits under this program.

Corrective Appliances: The general term for appliances or devices that support a weakened body part (orthotic) or replace a missing body part (prosthetic). To determine the category of any item, see also the definitions of Durable Medical Equipment, Nondurable Supplies, Orthotic Appliance (or device) and Prosthetic Appliance (or device).

Cosmetic Surgery or Treatment: Surgery or medical treatment to improve or preserve physical appearance, but not physical function. Cosmetic surgery or treatment includes medical, dental, or surgical treatment intended to restore or improve physical appearance, as determined by the Plan Administrator, UM company, or its designee.

Cost-Efficient: See the definition of medically necessary for the definition of cost-efficient as it applies to medical services that are medically necessary.

Cost sharing: The amount a participant or beneficiary is responsible for paying for a covered item or service under the terms of the plan. Cost sharing generally includes copayments, coinsurance, and amounts paid towards deductibles, but does not include amounts paid towards premiums, balance billing by Non-PPO providers, or the cost of items or services that are not covered under the plan.

Cost Sharing Amount: for Emergency and Non-emergency Services at PPO Facilities performed by Non-PPO Providers, and air ambulance services from Non-PPO providers will be based on the Recognized Amount.

Covered Individual: Any employee or retiree (as those terms are defined in this Plan), and that person's eligible spouse or dependent child who has completed all required formalities for enrollment for coverage under the Plan and is covered by the Plan.

Covered Medical Expenses: See the definition of *Eligible Medical Expenses*.

Custodial Care: Care and services given mainly for personal hygiene or to perform the activities of daily living. Some examples of custodial care are helping patients get in and out of bed, bathe, dress, eat, use the toilet, walk (ambulate), or take drugs or medicines that can be self-administered. These services are custodial care regardless of where the care is given or who recommends, provides, or directs the care. Custodial care can be given safely and adequately (in terms of generally accepted medical standards) by people who are not trained or licensed medical or nursing personnel. Custodial care may be payable by this Plan under certain circumstances, such as when custodial care is provided during a covered hospitalization or during a covered period of hospice care.

Customary Charge: See the definition of Usual and Customary Charge.

Deductible: The amount of eligible medical, prescription drug and dental expenses you are responsible for paying before the Plan begins to pay benefits. The dental Deductibles are

discussed in the separate PPO Dental Master Plan Document.

Dental: As used in this document, dental refers to any services performed by (or under the supervision of) a dentist, or supplies (including dental prosthetics). Dental services include treatment to alter, correct, fix, improve, remove, replace, reposition, restore or treat teeth; the gums and tissues around the teeth; the parts of the upper or lower jaws that contain the teeth (the alveolar processes and ridges); the jaw, any jaw implant, or the joint of the jaw (the Temporomandibular Joint); bite alignment, or the meeting of upper or lower teeth, or the chewing muscles; and/or teeth, gums, jaw or chewing muscles because of pain, injury, decay, malformation, disease or infection. Dental services and supplies coverage is provided in the PPO Dental Plan (refer to the separate PPO Dental Plan MPD available at www.pebp.state.nv.us) and are not covered under the medical expense coverage of this Plan unless the medical Plan specifically indicates otherwise in the *Schedule of Medical Benefits*.

Dependent: Any of the following individuals: Dependent child(ren), spouse or domestic partner as those terms are defined in this document.

Dependent Child(ren): See also (NAC 287.312)
For the purposes of this Plan, a dependent child is any of your children under the age of 26 years, including:

- natural child,
- child(ren) of a domestic partner,
- stepchild,
- legally adopted child or child placed in anticipation for adoption (the term placed for adoption means the assumption and retention by the employee of a legal obligation for total or partial support of the child in anticipation of adoption of the child and the child must be available for adoption and the legal adoption process must have commenced),
- child who qualifies for benefits under a QMCSO/NMSN (see the *Eligibility* section for details on QMCSO/NMSN),
- any other person who:
  (1) Bears a relationship described in 26 U.S.C. § 152(c)(2) to the participant or his or her spouse or domestic partner.
  (2) Is unmarried.
  (3) Has not attained the age set forth in 45 C.F.R. § 147.120(a).
  (4) Either resides with the participant or is enrolled in a program of secondary education or an independently accredited program of postsecondary education, including, without limitation, a college, university, community or junior college, graduate school or accredited trade or business school, on a full-time basis
  (5) Satisfies one of the following conditions:
    a. Is currently under a permanent legal guardianship of the participant or his or her spouse or domestic partner pursuant to chapter 159 of NRS; or

   b. Was eligible to be claimed as a dependent on the federal income tax return of the participant or his or her spouse or domestic partner for the immediately preceding calendar year; and
- Is in a relationship with the participant or his or her spouse or domestic partner that is like a child-parent relationship. The participant or his or her spouse or domestic partner must complete and submit to the Program an affidavit attesting to the fact of the relationship.

Disability: A determination by the Plan Administrator or its designee (after evaluation by a physician) that a person has a permanent or continuing physical or mental impairment causing the person to be unable to be self-sufficient as the result of having the physical or mental impairment such as intellectual disability, cerebral palsy, epilepsy, neurological disorder, or psychosis.

Domestic Partner: As defined by NRS 122A.030.

Drug: See the definition for prescription drug.

Durable Medical Equipment: Equipment that can withstand repeated use; and is primarily and customarily used for a medical purpose and is not generally useful in the absence of an injury or illness; and is not disposable or non-durable and is appropriate for the patient's home. Durable medical equipment includes (but is not limited to) apnea monitors, augmentation devices, blood sugar monitors, commodes, electric hospital beds with safety rails, electric and manual wheelchairs, nebulizers, oximeters, oxygen and supplies, and ventilators.

Elective Hospital Admission, Service or Procedure: Any non-emergency hospital admission, service or procedure that can be scheduled or performed at the patient's or physician's convenience without jeopardizing the patient's life or causing serious impairment of body function.

Eligible Medical Expenses: Expenses for medical services or supplies, but only to the extent that they are medically necessary; and the charges for them are usual and customary and do not exceed the Plan's Maximum Allowable Charge or negotiated fee schedule; and coverage for the services or supplies is not excluded (as provided in the *Exclusions* section); and the Plan Year maximum benefits for those services or supplies has not been reached.

Emergency: See the definition for Medical Emergency.

Emergency Medical Condition: A medical condition, including mental health condition or substance use disorder, manifested by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in serious impairment to bodily functions, serious dysfunction of any bodily organ or part, or placing the health of a woman or her unborn child in serious jeopardy.

Emergency Care: Medical and health services provided for an Emergency Medical Condition as defined above e

This Plan does not require precertification for medically necessary emergency services provided at any hospital in accordance with NRS 695G.170. For information, refer to the separate PEBP Health and Welfare Wrap Document available at www.pebp.state.nv.us.

Emergency Services means the following:

6. An appropriate medical screening examination that is within the capability of the emergency department of a hospital or of an independent freestanding emergency department, as applicable, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and
7. Within the capabilities of the staff and facilities available at the hospital or the independent freestanding emergency department, as applicable, such further medical examination and treatment as are required to stabilize the patient (regardless of the department of the hospital in which such further examination or treatment is furnished).

Emergency Services furnished by a Non-PPO provider or Non-PPO emergency facility (regardless of the department of the hospital in which such items or services are furnished) also include post stabilization services (services after the patient is stabilized) and as part of outpatient observation or an inpatient or outpatient stay related to the emergency medical condition, until:

- The provider or facility determines that the participant or beneficiary is able to travel using nonmedical transportation or nonemergency medical transportation; or
- The participant or beneficiary is supplied with a written notice, as required by federal law, that the provider is a Non-PPO provider with respect to the Plan, of the estimated charges for your treatment and any advance limitations that the Plan may put on your treatment, of the names of any PPO providers at the facility who are able to treat you, and that you may elect to be referred to one of the PPO providers listed; and
- The participant or beneficiary gives informed consent to continued treatment by the Non-PPO provider, acknowledging that the participant or beneficiary understands that continued treatment by the Non-PPO provider may result in greater cost to the participant or beneficiary.

See also NRS 695G.170.

Emergency Surgery: A surgical procedure performed within 24 hours of the sudden and unexpected severe symptom of an illness, or within 24 hours of an accidental injury causing a life-threatening situation.

Employee: Unless specifically indicated otherwise when used in this document, employee refers to a person employed by an agency or entity that participates in the PEBP program, and who is

eligible to enroll for coverage under this Plan.

Employer: Unless specifically indicated otherwise when used in this document, employer refers to an agency or entity that participates in the PEBP program, including (but not limited to) most State agencies, as well as some county and city agencies and organizations.

Enteral Formulas: Enteral Formulas is subject to NRS 689B.0353.

Exclusions: Specific conditions, circumstances, and limitations, as set forth in the *Exclusions* section for which the Plan does not provide Plan benefits.

Experimental and/or Investigational Services: See also NRS 695G.173: Required provision concerning coverage for treatment received as part of clinical trial or study.

Unless mandated by law, the Plan Administrator, UM company, or its designee has the discretion and authority to determine if a service or supply is, or should be, classified as experimental and/or investigational. A service or supply will be deemed to be experimental and/or investigational if, in the opinion of the Plan Administrator, UM company, or its designee, based on the information and resources available at the time the service was performed or the supply was provided, or the service or supply was considered for precertification under the Plan's utilization management program, any of the following conditions were present with respect to one or more essential provisions of the service or supply:

- The service or supply is described as an alternative to more conventional therapies in the protocols (the plan for the course of medical treatment that is under investigation) or consent document (the consent form signed by or on behalf of the patient) of the health care provider that performs the service or prescribes the supply.
- The prescribed service or supply may be given only with the approval of an Institutional Review Board as defined by federal law.
- In the opinion of the Plan Administrator or its designee, there is either an absence of authoritative medical, dental or scientific literature on the subject, or a preponderance of such literature published in the United States, and written by experts in the field, that shows that recognized medical, dental or scientific experts: classify the service or supply as experimental and/or investigational; or indicate that more research is required before the service or supply could be classified as equally or more effective than conventional therapies.
- With respect to services or supplies regulated by the Food and Drug Administration (FDA), FDA approval is required for the service and supply to be lawfully marketed; and it has not been granted at the time the service or supply is prescribed or provided; or a current Investigational new drug or new device application has been submitted and filed with the FDA. However, a drug will not be considered experimental and/or investigational if it is:
    - Approved by the FDA as an "Investigational new drug for treatment use"; or

- Classified by the National Cancer Institute as a Group C cancer drug when used for treatment of a "life threatening disease," as that term is defined in FDA regulations; or
- Approved by the FDA for the treatment of cancer and has been prescribed for the treatment of a type of cancer for which the drug was not approved for general use, and the FDA has not determined that such drug should not be prescribed for a given type of cancer.
- The prescribed service or supply is available to the covered person only through participation in Phase I or Phase II clinical trials; **or** Phase III Experimental or research clinical trials or corresponding trials sponsored by the FDA, the National Cancer Institute, or the National Institutes of Health.

In determining if a service or supply is or should be classified as experimental and/or Investigational, the Plan Administrator or its designee will rely only on the following specific information and resources that are available at the time the service or supply was performed, provided, or considered for precertification under the Plan's utilization management program:

- Medical records of the covered person.
- The consent document signed, or required to be signed, to receive the prescribed service or supply.
- Protocols of the health care provider that renders the prescribed service or prescribes or dispenses the supply.
- Authoritative peer-reviewed medical or scientific writings that are published in the United States regarding the prescribed service or supply for the treatment of the covered person's diagnosis, including (but not limited to) "United States Pharmacopoeia Dispensing Information"; and "American Hospital Formulary Service".
- The published opinions of the American Medical Association (AMA), such as "The AMA Drug Evaluations" and "The Diagnostic and Therapeutic Technology Assessment (DATTA) Program, etc.; or specialty organizations recognized by the AMA; or the National Institutes of Health (NIH); or the Center for Disease Control (CDC); or the Office of Technology Assessment; or the American Dental Association (ADA), with respect to dental services or supplies.
- Federal laws or final regulations that are issued by or applied to the FDA or Department of Health and Human Services regarding the prescribed service or supply.

The latest edition of "The Medicare Coverage Issues Manual."

NOTE: To determine how to obtain a precertification of any procedure that might be deemed to be experimental and/or investigational, see the *precertification* in the *Utilization Management* section.

Explanation of Benefits (EOB): When a claim is processed by the claims administrator you will be sent a form called an Explanation of Benefits, or EOB. The EOB describes how the claim was processed, such as allowed amounts, amounts applied to your Deductible, if your out-of-pocket maximum has been reached, if certain services were denied and why, amounts you need to pay

to the provider, etc.

Extended Care Facility: See the definition of Skilled Nursing Facility.

Expedited Appeal: If a participant appeals a decision regarding a denied request for precertification (pre-service claim) for an urgent care claim, the participant or participant's authorized representative can request an expedited appeal, either orally or in writing. Decisions regarding an expedited appeal are generally made within seventy-two (72) hours from the Plan's receipt of the request.

External Review: An independent review of an adverse benefit determination conducted by an external review organization.

External Review Organization: An organization that

1) conducts an external review of a final adverse benefit determination; and
2) is certified in accordance with regulations adopted by the Nevada Commissioner of Insurance.

Federal Legend Drugs: Any medicinal substance that the Federal Food, Drug and Cosmetic Act requires to be labeled, "Caution — Federal Law prohibits dispensing without prescription."

Food and Drug Administration (FDA): The U.S. government agency responsible for administration of the Food, Drug and Cosmetic Act and whose approval is required for certain prescription drugs and other medical services and supplies to be lawfully marketed.

Free-Standing Laboratory Facility: Free-standing laboratory facilities are stand-along facilities that are not affiliated with a hospital system. Examples of preferred free-standing laboratory facilities include Labor Corp or Quest.

Formulary: A list of generic and brand name drug products available for use by participants. This is maintained by the Pharmacy Benefit Manager and may be subject to change according to the Pharmacy Benefit Manager.

Gender Dysphoria: Gender Dysphoria, as defined by the American Psychiatric Association, refers to psychological distress that results from an incongruence between one's sex assigned at birth and one's gender identity. Generally, it is a condition in which the person has the desire to live as a member of the opposite sex and progressively take steps to live in the opposite sex role full-time.

Generic; Generic Drug: A prescription drug that has the equivalency of the brand name drug with the same use and metabolic disintegration. This Plan will consider as a generic drug any FDA approved generic pharmaceutical dispensed according to the professional standards of a licensed Pharmacist and clearly designated by the pharmacist as being generic. (See also the Prescription Drug section of the *Schedule of Medical Benefits* and the *Prescription Drug* subsection of the *Medical Exclusion* section).

Genetic Counseling: Counseling services provided before or in the absence of genetic testing to educate the patient about issues related to chromosomal abnormalities or genetically transmitted characteristics and/or the possible impacts of the results of genetic testing; and provided after Genetic Testing to explain to the patient and his or her family the significance of any detected chromosomal abnormalities or genetically transmitted characteristics that indicate either the presence of or predisposition to a disease or disorder of the individual tested, or the presence of or predisposition to a disease or disorder in a fetus of a pregnant woman.

Genetic Information: Information regarding the presence or absence of chromosomal abnormalities or genetically transmitted characteristics in a person that is obtained from genetic testing, or that may be inferred from a person's family medical history.

Genetic Testing: Tests that involve the extraction of DNA from an individual's cells and analysis of that DNA to detect the presence or absence of chromosomal abnormalities or genetically transmitted characteristics that indicate the presence of a disease or disorder, the individual's predisposition to a disease or disorder, or the probability that the chromosomal abnormality or characteristic will be transmitted to that person's child, who will then either have that disease or disorder, a predisposition to develop that disease or disorder, or become a carrier of that abnormality or characteristic with the ability to transmit it to future generations. Tests that assist the health care practitioner in determining the appropriate course of action or treatment for a medical condition.

Gestational Carrier: Gestational carrier means an adult woman who is not an intended parent and who enters into a gestational agreement to bear a child conceived using the gametes of other persons and not her own. NRS 126.580

Government-Provided Services: Expenses for health care services provided to a covered participant that federal, state, or local law (e.g., Tricare/Champus, VA, except the Medicaid program), expenses for care required by a public entity and care for which there would not normally be a charge.

Health Care Facility: (for non-emergency services) is each of the following:

1. A hospital (as defined in section 1861(e) of the Social Security Act);
2. A hospital outpatient department;
3. A critical access hospital (as defined in section 1861(mm)(1) of the Social Security Act); and
4. An ambulatory surgical center described in section 1833(i)(1)(A) of the Social Security Act

Health Care Practitioner: A physician, behavioral health practitioner, chiropractor, dentist, nurse, nurse practitioner, physician assistant, podiatrist, or occupational, physical, respiratory or speech therapist or speech pathologist, master's prepared audiologist, optometrist, optician for vision Plan benefits, oriental medicine doctor for acupuncture or Christian Science Practitioner, or other provider who is legally licensed and/or legally authorized to practice or provide certain health

care services under the laws of the state or jurisdiction where the services are rendered: and acts within the scope of his or her license and/or scope of practice.

Health Care Provider: A health care practitioner as defined above, or a hospital, ambulatory surgical facility, behavioral health treatment facility, birthing center, home health care agency, hospice, skilled nursing facility, or sub-acute care facility (as those terms are defined in this *Key Terms and Definitions* section).

HIPAA: Health Insurance Portability and Accountability Act of 1996. Federal regulation affecting portability of coverage; electronic transmission of claims and other health information; privacy and confidentiality protections of health information.

HIPAA Special Enrollment: Enrollment rights under HIPAA for certain employees and dependents who experience a loss of other coverage and when there is an adoption, placement for adoption, birth, or marriage.

Home Health Care: Intermittent skilled nursing care services provided by a licensed home health care agency (as those terms are defined in this section).

Home Health Care Agency: An agency or organization that provides a program of Home Health Care and meets one of the following three tests:

- It is approved by Medicare; or
- It is licensed as a home health care agency by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located; or
- If licensing is not required, it meets all the following requirements:
- It has the primary purpose of providing a home health care delivery system bringing supportive skilled nursing and other therapeutic services under the supervision of a physician or registered nurse to the home.
- It has a full-time administrator.
- It is run according to rules established by a group of professional health care providers including physicians and registered nurses.
- It maintains written clinical records of services provided to all patients.
- Its staff includes at least one registered nurse, or it has nursing care by a registered nurse available.
- Its employees are bonded.
- It maintains malpractice insurance coverage.

Homeopathy: A school of medicine based on the theory that when large doses of drugs or substances produce symptoms of an illness in healthy people, administration of very small doses of those drugs or substances will cure the same symptoms. Homeopathy principles are designed to enhance the body's natural protective mechanisms based on a theory that "like cures like" or "treatment by similar." See also the *Exclusions* section of this document regarding homeopathic treatment and services. When the services of homeopaths are payable by this Plan (e.g., an office

visit), the homeopath must be properly licensed to practice homeopathy in the state in which he or she is practicing and must be performing services within the scope of that license or, where licensing is not required, have successfully graduated with a diploma of Doctor of Medicine in Homeopathy from an institution which is approved by the American Institute of Homeopathy and completed at least 90 hours of formal post- graduate courses or training in a program approved by the American Institute of Homeopathy.

Hospice: An agency or organization that administers a program of palliative and supportive health care services providing physical, psychological, social, and spiritual care for terminally ill persons assessed to have a limited life expectancy. Hospice care is intended to let the terminally ill spend their last days with their families at home (home hospice services) or in a home-like setting (inpatient hospice), with emphasis on keeping the patient as comfortable and free from pain as possible and providing emotional support to the patient and his or her family.

A hospice agency must meet one of the following tests:

- It is approved by Medicare; or is licensed as a hospice agency by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located; or
- If licensing is not required, it meets all the following requirements:
    a. It provides 24 hour-a-day, 7 day-a-week service.
    b. It is under the direct supervision of a duly qualified physician.
    c. It has a full-time administrator.
    d. It has a nurse coordinator who is a registered nurse with four years of full-time clinical experience. Two of these years must involve caring for terminally ill patients.
    e. The main purpose of the agency is to provide hospice services.
    f. It maintains written records of services provided to the patient.
    g. It maintains malpractice insurance coverage.
    h. A hospice agency that is part of a hospital will be considered a hospice agency for the purposes of this Plan.

Hospital: A public or private facility or institution, other than one owned by the U.S Government, licensed and operating according to law, that:

- Is legally operated in the jurisdiction where it is located.
- Is engaged mainly in providing inpatient medical care and treatment for injury and illness in return for compensation.
- Has organized facilities for diagnosis and major surgery on its premises.
- Is supervised by a staff of at least two physicians.
- Has 24-hour-a-day nursing service by registered nurses; and
- Is not a facility specializing in dentistry; or an institution which is mainly a rest home; a home for the aged; a place for drug addicts; a place for alcoholics; a convalescent home; a nursing home; an extended care or skilled nursing facility or similar institution; or a Long-Term Acute Care Facility (LTAC).

A hospital may include facilities for behavioral health treatment that are licensed and operated according to law. Any portion of a hospital used as an ambulatory surgical facility, birth (or birthing) center, hospice, skilled nursing facility, sub-acute care facility, or other place for rest, custodial care, or the aged shall not be regarded as a hospital for any purpose related to this Plan.

Illness: Any bodily sickness or disease, including any congenital abnormality of a newborn child, as diagnosed by a physician, and as compared to the person's previous condition. Pregnancy of a covered employee or covered spouse will be an illness only for coverage under this Plan. However, infertility is not an illness for coverage under this Plan.

Independent Freestanding Emergency Department: A health-care facility (not limited to those described in the definition of health care facility) that is geographically separate and distinct from a hospital under applicable State law and provides Emergency Services.

Inherited Metabolic Disorder: A genetically acquired disorder of metabolism involving the inability to properly metabolize amino acids, carbohydrates, or fats, as diagnosed by a physician using standard blood, urine, spinal fluid, tissue, or enzyme analysis. Inherited Metabolic Disorders are also referred to as inborn errors of metabolism and include Phenylketonuria (PKU), Maple Syrup Urine Disease, Homocystinuria and Galactosemia. Lactose intolerance without a diagnosis of Galactosemia is not an Inherited Metabolic Disorder under this Plan. See Special Food Products.

Injury: Any damage to a body part resulting from trauma from an external source.

Injury to Teeth (ISNT): An injury to the teeth caused by trauma from an external source. This does not include an injury to the teeth caused by any intrinsic force, such as the force of biting or chewing. Benefits for injury to teeth are payable under the medical Plan (see also the definition of Teeth).

In-Network Provider: Means an In-Network provider that the network or one of its rental networks have contracted with or have arrangements with to provide health services to covered individuals. An In-Network provider has agreed to charge participants a discounted rate. To determine if a provider is an In-Network provider log on to www.pebp.state.nv.us. You may also call the number of the back of your ID card and a customer service representative can help you locate an In-Network provider.

In-Network Services: Services provided by a health care provider that is a member of the Plan's Exclusive Provider Organization (EPO), as distinguished from Out-of-Network services that are provided by a health care provider that is not a member of the EPO network.

In-Network Contracted Rate: The negotiated amount determined by the EPO network to be the maximum amount charged by the EPO provider for a covered service. In some cases, the In-Network contracted amount may be applied to Out-of-Network provider charges.

Inpatient Services: Services provided in a hospital or other health care facility during the period when charges are made for room and board.

Intensive Care Unit: A section, ward, or wing within the hospital which:

- Is separated from other hospital facilities.
- Is operated exclusively for providing professional care and treatment for critically ill patients.
- Has special supplies and equipment necessary for such care and treatment available on a standby basis for immediate use.
- Provides room and board; and
- Provides constant observation and care by registered nurses or other specially trained hospital personnel.

Intensive Outpatient Program: An intensive outpatient program (IOP) is a kind of treatment service and support program used primarily to treat eating disorders, depression, self-harm, and chemical dependency that does not rely on detoxification. IOP operates on a small scale and does not require the intensive residential or partial day services typically offered by the larger, more comprehensive treatment facilities.

Maintenance Care: Services and supplies provided primarily to maintain, support and/or preserve a level of physical or mental function rather than to improve such function.

Maintenance Rehabilitation refers to therapy in which a patient actively participates, that is provided after a patient has met the functional goals of active rehabilitation so that no continued significant and measurable improvement is reasonably and medically anticipated, but where additional therapy of a less intense nature and decreased frequency may reasonably be prescribed to maintain, support, and or preserve the patient's functional level. Maintenance rehabilitation is not covered by the Plan.

Managed Care: Procedures designed to help control health care costs by avoiding unnecessary services or services that are costlier than others that can achieve the same result.

Maximum Amount; Maximum Allowable Charge: The benefit payable for a specific coverage item or benefit under the Plan. Maximum allowable charge(s) shall be calculated by the Plan Administrator considering and after having analyzed:

- The reasonable and appropriate amount.
- The terms of the Plan:
- Plan negotiated and contractual rates with provider(s).
- The actual billed charges for the covered services; and
- Unusual circumstances or complications requiring additional time, skill, and experience in connection with a service or supply, industry standards and practices as they relate to similar scenarios, and the cause of injury or illness necessitating the service(s) and/or charge(s).

- Medicare Allowable

The Plan will reimburse the actual charge(s) if they are less than the Plan's Maximum Allowable Charge amount(s). The Plan has the discretionary authority to decide if a charge is reasonable and appropriate, as well as medically necessary. The Maximum Allowable Charge will not include any identifiable billing mistakes including, but not limited to, up-coding, duplicate charges, and charges for services not performed.

Medically Necessary: A medical or dental service or supply will be determined to be "medically necessary" by the Plan Administrator or its designee if it:

- Is provided by or under the direction of a physician or other duly licensed health care practitioner who is authorized to provide or prescribe it (or dentist if a dental service or supply is involved); and
- Is determined by the Plan Administrator or its designee to be necessary in terms of generally accepted American Medical and Dental standards; and
- Is determined by the Plan Administrator or its designee to meet all the following requirements:
- It is consistent with the symptoms or diagnosis and treatment of the illness or injury; and
- It is not provided solely for the convenience of the patient, physician, dentist, hospital, health care provider, or health care facility; and
- It is an appropriate service or supply given the patient's circumstances and condition; and
- It is a cost-efficient supply or level of service that can be safely provided to the patient; and
- It is safe and effective for the illness or injury for which it is used.

A medical or dental service or supply will be appropriate if:

- It is a diagnostic procedure that is called for by the health status of the patient and is: as likely to result in information that could affect the course of treatment as; and no more likely to produce a negative outcome than any alternative service or supply, both with respect to the illness or injury involved and the patient's overall health condition.
- It is care or treatment that is likely to produce a significant positive outcome; and no more likely to produce a negative outcome than any alternative service or supply, both with respect to the illness or injury involved and the patient's overall health condition.
- A medical or dental service or supply will be cost-efficient if it is no costlier than any alternative appropriate service or supply when considered in relation to all health care expenses incurred in connection with the service or supply. The fact that your physician or dentist may provide, order, recommend or approve a service or supply does not mean that the service or supply will be medically necessary for the medical or dental coverage provided by the Plan. A hospitalization or confinement to a health care facility will not be

medically necessary if the patient's illness or injury could safely and appropriately be diagnosed or treated while not confined. A medical or dental service or supply that can safely and appropriately be furnished in a physician's or dentist's office or other less costly facility will not be medically necessary if it is furnished in a hospital or health care facility or other costlier facility:

- The non-availability of a bed in another health care facility, or the non-availability of a Health Care Practitioner to provide medical services will not result in a determination that continued confinement in a hospital or other health care facility is medically necessary.
- A medical or dental service or supply will not be considered medically necessary if it does not require the technical skills of a dental or health care practitioner or if it is furnished mainly for the personal comfort or convenience of the patient, the patient's family, any person who cares for the patient, any dental or health care practitioner, hospital, or health care facility.

Medically Necessary for External Review: Means health care services or products that a prudent physician would provide to a patient to prevent, diagnose or treat an illness, injury or disease or any symptoms thereof that are necessary and provided in accordance with generally accepted standards of medical practice, is clinically appropriate with regard to type, frequency, extent, location and duration, is not primarily provided for the convenience of the patient, physician or other provider of healthcare, is required to improve a specific health condition of a member or to preserve his existing state of health and the most clinically appropriate level of healthcare that may be safely provided to the participant.

Medicare: The Health Insurance for the Aged and Disabled provisions in Title XVIII of the U.S. Social Security Act as it is now amended and as it may be amended in the future.

Medicare Part A: Hospital insurance provided by the federal government that helps cover inpatient care in hospitals, skilled nursing facility, hospice, and home health care.

Medicare Part B: Medical insurance provided by the federal government that helps pay for medically necessary services like doctors' services, outpatient care, durable medical equipment, home health services, and other medical services.

Medicare Part D: Prescription drug coverage subsidized by the federal government but is offered only by private companies contracted with Medicare such as HMOs and PPOs.

Medi-Span: A national drug pricing information database for drug pricing analysis and comparison.

Mental Disorder; Mental and Nervous Disorder: See the definition of Behavioral Health Disorder.

Midwife, Nurse Midwife: A person legally licensed as a Midwife or certified as a Certified Nurse Midwife in the area of managing the care of mothers and babies throughout the maternity cycle, as well as providing general gynecological care, including history taking, performing physical

examinations, ordering laboratory tests and x-ray procedures, managing labor, delivery and the post-delivery period, administer intravenous fluids and certain medications, provide emergency measures while awaiting aid, perform newborn evaluation, sign birth certificates, and bill and be paid in his or her own name, and who acts within the scope of his or her license. A Midwife may not independently manage moderate or high-risk mothers, admit to a hospital, or prescribe all types of medications. See also the definition of Nurse.

Morbid Obesity: Characterized by body mass index >40 kg/m(2) as defined by the National Library of Medicine.

Naturopathy: A therapeutic system based on principles of treating diseases with natural forces such as water, heat, diet, sunshine, stress reduction, physical manipulation, massage, or herbal tea. Note: Naturopathy providers, treatment, services, or substances are not a payable benefit under this Plan.

No Surprises Act means the federal No Surprises Act (Public Law 116-260, Division BB).

Nondurable Supplies: Goods or supplies that cannot withstand repeated use and/or that are considered disposable and limited to either use by a single person or one-time use, including (but not limited to) bandages, hypodermic syringes, diapers, soap, or cleansing solutions, etc. See also the definitions of Corrective Appliances, Durable Medical Equipment, Orthotic Appliance (or Device) and Prosthetic Appliance (or Device). Only those Nondurable Supplies identified in the *Schedule of Medical Benefits* are covered by this Plan. All others are not.

Non-Network: See Out-of-Network.

Non-PPO emergency facility: An emergency department of a hospital, or an independent freestanding emergency department (or a hospital, with respect to Emergency Services as defined), that does not have a contractual relationship directly or indirectly with a group health plan or group health insurance coverage offered by a health insurance issuer, with respect to the furnishing of an item or service under the plan or coverage respectively

Non-PPO Provider or Non-Participating Provider: A health care provider who does not have a contractual relationship directly or indirectly with the Plan with respect to the furnishing of an item or service under the Plan.

Nurse: A person legally licensed as a Registered Nurse (RN), Certified Registered Nurse Anesthetist (CRNA), Certified Nurse Midwife or licensed Midwife, Nurse Practitioner (NP), Licensed Practical Nurse (LPN), Licensed Vocational Nurse (LVN), Psychiatric Mental Health Nurse, or any equivalent designation, under the laws of the state or jurisdiction where the services are rendered, who acts within the scope of his or her license.

Nurse Anesthetist: A person legally licensed as a Certified Registered Nurse Anesthetist (CRNA), Registered Nurse Anesthetist (RNA) or Nurse Anesthetist (NA) and authorized to administer Anesthesia in collaboration with a physician, and bill and be paid in his or her own name, or any

equivalent designation, under the laws of the state or jurisdiction where the services are rendered, who acts within the scope of his or her license.

Nurse Practitioner: A person legally licensed as a Nurse Practitioner (NP), or Registered Nurse Practitioner (RNP) who acts within the scope of his or her license and who in collaboration with a physician, examines patients, establishes medical diagnoses; orders, performs and interprets laboratory, radiographic and other diagnostic tests, identifies, develops, implements and evaluates a plan of patient care, prescribes and dispenses medication, refers to and consults with appropriate health care practitioners under the laws of the state or jurisdiction where the services are rendered.

Obesity: Body mass index of 30 kg/m2 or higher is used to identify individuals with obesity as defined by the National Library of Medicine.

Occupational Therapist: A person legally licensed as a professional occupational therapist who acts within the scope of their license and acts under the direction of a physician to assess the presence of defects in an individual's ability to perform self-care skills and activities of daily living and who formulates and carries out a plan of action to restore or support the individual's ability to perform such skills to regain independence.

Office Visit: A direct personal contact between a physician or other health care practitioner and a patient in the health care practitioner's office for diagnosis or treatment associated with the use of the appropriate office visit code in the Current Procedural Terminology (CPT) manual of the American Medical Association and with documentation that meets the requirement of such CPT coding. Neither a telephone discussion with a physician or other health care practitioner nor a visit to a health care practitioner's office solely for such services as blood drawing, leaving a specimen, or receiving a routine injection is an office visit for the purposes of this Plan.

Open Enrollment Period: The period during which participants in the Plan may select among the alternate health benefit programs that are offered by the Plan or eligible individuals not currently enrolled in the Plan may enroll for coverage.

Oral Surgery: The specialty of dentistry concerned with surgical procedures in and about the mouth and jaw.

Orthognathic Services: Services dealing with the cause and treatment of malposition of the bones of the jaw, such as Prognathism, Retrognathism or TMJ syndrome. See the definitions of Prognathism, Retrognathism and TMJ.

Orthotic (Appliance or Device): A type of corrective appliance or device, either customized or available "over-the-counter," designed to support a weakened body part, including (but not limited to) crutches, custom designed corsets, leg braces, extremity splints, and walkers. For the purposes of the medical Plan, this definition does not include dental orthotics. See also the definitions of Corrective Appliance, Durable Medical Equipment, Nondurable Supplies and Prosthetic Appliance (or Device).

Other Prescription Drugs: Drugs that require a prescription under state law but not under federal law.

Out-of-Network Rate: With respect to items and services furnished by a Non-PPO provider, Non-Network emergency facility or Non-PPO provider of ambulance services, means one of the following:

- the amount the parties negotiate;
- the amount approved under the independent dispute resolution (IDR) process; or

if the state has an All-Payer Model Agreement, the amount that the state approves under that system

Out-of-Network Services (Non-Network): Services provided by a health care provider that is not a member of the Plan's Preferred Provider Organization (PPO), as distinguished from In-Network services that are provided by a health care provider that is a member of the PPO. Greater expense could be incurred by the participant when using Out-of-Network providers.

Out-of-Pocket Maximum: The maximum amount of Coinsurance each covered person or family is responsible for paying during a Plan Year before the Coinsurance required by the Plan ceases to apply. When the Out-of-Pocket Maximum is reached, the Plan will pay 100% of eligible covered expenses for the remainder of the Plan Year. See the section on Out-of-Pocket Maximum in the *Medical Expense Coverage* section for details about what expenses do not count toward the Out-of-Pocket Maximum.

Outpatient Hospital Laboratory and Outpatient Hospital-Based Laboratory Draw Station: Outpatient hospital-based laboratory facilities include lab services performed in a hospital outpatient setting. Outpatient hospital-based laboratory draw stations are hospital affiliated whereby the draw station collects specimens and sends them to the central hospital lab for processing.

Outpatient Services: Services provided either outside of a hospital or health care facility setting or at a hospital or health care facility when room and board charges are not incurred.

Partial Hospitalization Service: Also known as PHP, is a type of program used to treat mental illness and substance abuse in which the patient continues to reside at home but commutes to a treatment center up to seven days a week. This service model focuses on the overall treatment of the individual and is intended to avert or reduce in-patient hospitalization. Services are typically provided in either a hospital setting or by a free-standing community mental health center. Treatment during a typical day may include group therapy, psych-educational groups, skill building, individual therapy, and psychopharmacological assessments, and check-ins. Programs are available for the treatment of alcoholism and substance abuse, Alzheimer's disease, anorexia and bulimia, depression, bipolar disorder, anxiety disorders, schizophrenia, and other mental illnesses.

Participant: The employee or retiree or their enrolled spouse or domestic partner or dependent child(ren) or a surviving spouse or dependent of a retiree. NAC 287.095

Participating Provider: A health care provider who participates in the Plan's Exclusive Provider Organization (EPO).

Passive Rehabilitation: Refers to therapy in which a patient does not actively participate because the patient does not have the ability to learn and/or remember (that is, has a cognitive deficit), or is comatose or otherwise physically or mentally incapable of active participation. Passive rehabilitation may be covered by the Plan, but only during a course of hospitalization for acute care. Techniques for passive rehabilitation are commonly taught to the family/caregivers to employ on an outpatient basis with the patient when and until the patient can achieve active rehabilitation. Continued hospitalization for the sole purpose of providing passive rehabilitation will not be medically necessary for the purposes of this Plan.

Pharmacy: A licensed establishment where covered prescription drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he or she practices.

Pharmacist: A person legally licensed under the laws of the state or jurisdiction where the services are rendered, to prepare, compound and dispense drugs and medicines, and who acts within the scope of his or her license.

Physical Therapy: Rehabilitation directed at restoring function following disease, injury, surgery, or loss of body part using therapeutic properties such as active and passive exercise, cold, heat, electricity, traction, diathermy, and/or ultrasound to improve circulation, strengthen muscles, return motion, and/or train/retrain an individual to perform Activities of daily living such as walking and getting in and out of bed.

Physician: A person legally licensed as a Medical Doctor (MD) or Doctor of Osteopathy (DO) and authorized to practice medicine, to perform surgery, and to administer drugs, under the laws of the state or jurisdiction where the services are rendered who acts within the scope of his or her license.

Physician Assistant (PA): A person legally licensed as a physician assistant, who acts within the scope of his or her license and acts under the supervision of a physician to examine patients, establish medical diagnoses; order, perform and interpret laboratory, radiographic and other diagnostic tests; identify, develop, implement and evaluate a plan of patient care; prescribe and dispense medication within the limits of his or her license; refer to and consult with the supervising physician; under the laws of the state or jurisdiction where the services are rendered.

Plan, The Plan, This Plan: In most cases, the programs, benefits, and provisions described in this document as provided by the Public Employees' Benefits Program (PEBP).

Plan Administrator: The person or legal entity designated by the Plan as the party who has the fiduciary responsibility for the overall administration of the Plan.

Plan Year: Typically, the 12-month period from July 1 through June 30. PEBP has the authority to revise the Plan Year if necessary. PEBP has the authority to revise the benefits and rates, if necessary, each Plan Year. For medical, dental, vision and pharmacy benefits, all Deductibles, Out-of-Pocket Maximums and Plan Year maximum benefits are determined based on the Plan Year.

Plan Year Deductible: The amount you must pay each Plan Year before the Plan pays benefits.

Plan Year Maximum Benefits: The maximum amount of benefits payable each Plan Year for certain medical expenses incurred by any covered Plan participant (or covered family member of the Plan participant).

Podiatrist: A person legally licensed as a Doctor of Podiatric Medicine (DPM) who acts within the scope of his or her license and who is authorized to provide care and treatment of the human foot (and in some states, the ankle and leg up to the knee) under the laws of the state or jurisdiction where the services are rendered.

Positive Annual Open Enrollment Period: This process requires that each eligible employee or eligible retiree affirmatively make his or her benefit elections during the PEBP annual enrollment period. Even if you do not want to make any coverage changes, you must affirmatively make your elections, or you will be defaulted to self-coverage only under the PEBP base Plan.

Pre-Admission Testing: Laboratory tests and x-rays and other medically necessary tests performed on an outpatient basis, 7 days prior to a scheduled hospital admission or outpatient surgery. The testing must be related to the sickness or injury.

Precertification (preauthorization, prior authorization): Is a process used by the UM company and Pharmacy Benefit Manager to determine if a prescribed procedure, including, but not limited to inpatient admission, concurrent review, DME, outpatient services, or medication are medically necessary before the services and supplies are received. A precertification is not a guarantee of payment.

Exclusive Provider Organization (EPO): A group or network of health care providers (e.g., hospitals, physicians, laboratories) under contract with the Plan to provide health care services and supplies at agreed-upon discounted or reduced rates.

Prescribed for a Medically Necessary Indication: The term medically necessary indication means any use of a covered outpatient drug which is approved under the Federal Food, Drug and Cosmetic Act, or the use of which is supported by one or more citations included or approved for inclusion in any of the following compendia: American Hospital Formulary Service Drug Information, United States Pharmacopeia-Drug Information, the DRUGDEX Information System or American Medical Association Drug Evaluations.

Prescription Drugs: For the purposes of this Plan, prescription drugs include:

- Federal Legend Drugs: Any medicinal substance that the Federal Food, Drug, and Cosmetic Act requires to be labeled, "Caution - Federal law prohibits dispensing without prescription".
- Other prescription drugs: drugs that require a prescription under state law but not under federal law; or
- Compound drugs: Any drug that has more than one ingredient and at least one of them is a Federal Legend Drug or a drug that requires a prescription under state law.

Prescription Prior Authorization (PA): Also known as "coverage review," this is a process the Plan's Pharmacy Benefit Manager might use to decide if your prescribed medicine will be covered. The Plan uses this to help control costs and to ensure the medicine being prescribed is an effective treatment for the condition.

Primary Care Physician (PCP): A physician in family practice, internal medicine, obstetrics and gynecology and pediatrics.

Prognathism: The malposition of the bones of the jaw resulting in projection of the lower jaw beyond the upper part of the face.

Program: Means the Public Employees' Benefits Program established in accordance with NRS 287.0402 to 287.049, inclusive.

Prophylactic Surgery: A surgical procedure performed for

1) avoiding the possibility or risk of an illness, disease, physical or mental disorder or condition based on genetic information or genetic testing, or
2) treating the consequences of chromosomal abnormalities or genetically transmitted characteristics, when there is an absence of objective medical evidence of the presence of disease or physical or mental disorder, even at its earliest stages.

An example of prophylactic surgery is a mastectomy performed on a woman who has been diagnosed as having a genetic predisposition to breast cancer or has a history of breast cancer among her family members when, at the time the surgery is to be performed, there is no objective medical evidence of the presence of the disease, even if there is medical evidence of a chromosomal abnormality or genetically transmitted characteristic indicating a significant risk of breast cancer coupled with a history of breast cancer among family members of the woman.

Prophylaxis: The removal of tartar and stains from the teeth. The cleaning and scaling of the teeth are performed by a dentist or dental hygienist.

Prospective Payment System (PPS): This Plan follows CMS's Prospective Payment System (PPS) where the Plan's payment is based on a predetermined, fixed amount payable to a facility for inpatient or outpatient hospital services. The Plan will not allow separate reimbursement for

specific HCPCS supplies, DME, orthotics, prosthetics, biological, and drugs billed on a HCFA claim form by any physician or other qualified healthcare professional in the following facility POS (place of service) 19, 21, 22, 23, and 24, see the following POS descriptions:

- **POS 19 Off Campus – Outpatient Hospital:** A portion of an off-campus hospital provider-based department which provides diagnostic, therapeutic (both surgical and non-surgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.
- **POS 21 Inpatient Hospital:** A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and nonsurgical), rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.
- **POS 22 On Campus – Outpatient Hospital:** A portion of a hospital's main campus which provides diagnostic, therapeutic (both surgical and non-surgical), and rehabilitation services by, or under, the supervision physicians to patients admitted for a variety of medical conditions.
- **POS 23 Emergency Room – Hospital:** A portion of a hospital where emergency diagnosis and treatment of illness and injury is provided.
- **POS 24 Ambulatory Surgery Center:** A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.

Prosthetic Appliance (or Device): A type of corrective appliance or device designed to replace all or part of a missing body part, including (but not limited to) artificial limbs, heart pacemakers, or corrective lenses needed after cataract surgery. See also the definitions of Corrective Appliances, Durable Medical Equipment, Nondurable Supplies and Orthotic Appliance (or Device).

Provider: A health care practitioner as defined above, or a hospital, ambulatory surgical facility, behavioral health treatment facility, birthing center, home health care agency, hospice, skilled nursing facility, or sub-acute care facility (as those terms are defined in this *Key Terms and Definitions* Section).

Qualified Individual: A covered individual who is eligible, according to clinical trial protocol, to participate in an approved clinical trial and either: (i) the referring health care professional is an in-network provider and has concluded that the covered individual's participation in the clinical trial would be appropriate; or (ii) the covered individual provided medical and scientific information establishing that the individual's participation in the clinical trial would be appropriate.

Qualified Medical Child Support Orders (QMCSO): QMCSOs are state court orders requiring a parent to provide medical support to a child often because of legal separation or divorce, and also include a National Medical Support Notice A QMCSO may require the Plan to make coverage available to your child even though, for income tax or Plan purposes, the child is not your dependent. To qualify, a medical support order must be a judgment, decree, or order

(including approval of a settlement agreement) issued by a court of competent jurisdiction or by an administrative agency, which:

- Specifies your last known name and address and the child's last known name and address.
- Describes the type of coverage to be provided, or how the type of coverage will be determined.
- States the period to which it applies; and
- Specifies each plan to which it applies.

The QMCSO cannot require the Plan to cover any type or form of benefit that they do not currently cover. The Plan must pay benefits directly to the child, or to the child's custodial parent or legal guardian, consistent with the terms of the order and Plan provisions. You and the affected child will be notified if an order is received.

Quantity Limit: The maximum amount of a medication the Plan covers during a period of time. These limits are set for safety reasons and to help reduce costs.

Qualifying Payment Amount (QPA) means the amount calculated using the methodology described in 29 CFR 716-6(c).

Reasonable and/or Reasonableness: Means charges for services or supplies which are necessary for the care and treatment of an illness or injury. The determination that charges are reasonable will be made by the Plan Administrator taking into consideration the following:

- The facts and circumstances giving rise to the need for the service or supply.
- Industry standards and practices as they are related to similar scenarios; and
- The cause of the injury or illness necessitating the service or charge.

The Plan Administrator's determination will consider but will not be limited to evidence-based guidelines, and the findings and assessments of the following entities:

(a) The National Medical Associations, Societies, and Organizations;
(b) The Centers for Medicare and Medicaid Services (CMS);
(c) Centers for Disease Control and Prevention; and
(d) The Food and Drug Administration.

To be reasonable, charges must follow generally accepted billing practices for unbundling or multiple procedures. The Plan Administrator retains discretionary authority to determine whether a charge is reasonable. The Plan reserves for itself and parties acting on its behalf the right to review charges processed and/or paid by the Plan, to identify charges that are not reasonable and therefore not eligible for payment by the Plan.

Recognized Amount: means (in order of priority) one of the following:

1. An amount determined by an applicable All-Payer Model Agreement under section 1115A of the Social Security Act;
2. An amount determined by a specified state law; or
3. The lesser of the amount billed by the provider or facility or the Qualifying Payment Amount (QPA)

For air ambulance services furnished by Non-PPO providers, **Recognized Amount** is the lesser of the amount billed by the provider or facility or the Qualifying Payment Amount (QPA).

Reconstructive Surgery: A medically necessary surgical procedure performed on an abnormal or absent structure of the body to correct damage caused by a congenital birth defect, an accidental injury, infection, disease, or tumor, or for breast reconstruction following a total or partial mastectomy.

Reference Based Pricing/Reference Price: A methodology that determines the cost for a covered service based on a market or industry benchmark or reference price. The Plan Administrator may utilize this method in determining the Maximum Allowable Charge.

Rehabilitation Therapy: Physical, occupational, or speech therapy that is prescribed by a physician when the bodily function has been restricted or diminished as a result of illness, injury or surgery, with the goal of improving or restoring bodily function by a significant and measurable degree to as close as reasonably and medically possible to the condition that existed before the injury, illness, surgery, or medically necessary treatment of a behavioral health condition and that is performed by a licensed therapist acting within the scope of his or her license. See the *Schedule of Medical Benefits* and the *Exclusions* section of this document to determine the extent to which rehabilitation therapies are covered. See also the definition of Physical Therapy, Occupational Therapy, Speech Therapy and Cardiac Rehabilitation.

Reimbursable Payments: Payments made by this Plan for benefits, including any payment for a covered pre-existing condition that are or become the responsibility of another party under the subrogation provisions as described in this MPD.

Rescission: A cancellation or discontinuance of coverage under the Plan that has a retroactive effect. Rescission does not include a cancellation or discontinuance of coverage under the Plan if

(a) The cancellation or discontinuance of coverage has only a prospective effect; or
(b) The cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage; or
(c) fraud.

Retiree: Unless specifically indicated otherwise, when used in this document, Retiree refers to a person formerly employed by an agency or entity that may or may not participate in the PEBP program and who is eligible to enroll for coverage under this Plan.

Retrognathism: The malposition of the bones of the jaw resulting in the retrogression of the lower jaw from the upper part of the face.

Retrospective Review: Review of health care services after they have been provided to determine if those services were medically necessary and/or if the charges for them are Usual and Customary Charges and do not exceed the Plan's Maximum Allowable Charge or negotiated fee schedule.

Second Opinion: A consultation and/or examination, preferably by a board-certified physician not affiliated with the primary attending physician, to evaluate the medical necessity and advisability of undergoing surgery or receiving a medical service.

Serious and Complex Condition: With respect to a participant, beneficiary, or enrollee under the Plan one of the following:

4. in the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm;
5. in the case of a chronic illness or condition, a condition that is—
    a. is life-threatening, degenerative, potentially disabling, or congenital; and
    b. requires specialized medical care over a prolonged period of time.

Service Area: The geographic area serviced by the In-Network providers who have agreements with the Plan's network.

Sickle Cell Disease: An inherited disease caused by a mutation in a gene for hemoglobin in which red blood cells have an abnormal crescent shape that causes them to block small blood cells and die sooner than normal red blood cells and may include sickle cell disease, one or more variants or a combination thereof, as applicable. See also NRS 439.4927.**Significantly Inferior Coverage:** The PEBP Board has defined Significantly Inferior Coverage as either:

- A mini-med or other limited benefit plan; or
- Catastrophic coverage plans with a Deductible equal to or greater than $5,000 for single coverage with no employer contributions to a Health Savings Account or Health Reimbursement Arrangement.

Skilled Nursing Care: Services performed by a licensed nurse (RN, LVN or LPN) if the services are ordered by and provided under the direction of a physician; and are intermittent and part-time, generally not exceeding 16 hours a day, and are usually provided on less-than-daily basis; and require the skills of a nurse because the services are so inherently complex that they can be safely and effectively performed only by or under the supervision of a nurse. Examples of skilled nursing care services include but are not limited to the initiation of intravenous therapy and the initial management of medical gases such as oxygen.

Skilled Nursing Facility or Extended Care/Skilled Nursing Facility: A public or private facility,

licensed and operated according to law, that primarily provides skilled nursing and related services to people who require medical or nursing care and that rehabilitates injured, sick people or people with disabilities, and that meets all the following requirements:

- Is licensed pursuant to state and local laws.
- Is operated primarily for providing skilled nursing care and treatment for individuals convalescing from injury or illness.
- Is approved by and is a participating facility with Medicare.
- Has organized facilities for medical treatment.
- Provides 24-hour-a-day nursing service under the full-time supervision of a physician or registered nurse.
- Maintains daily clinical records on each patient.
- Has available the services of a physician under an established agreement.
- Provides appropriate methods for dispensing and administering drugs and medicines.
- Has transfer arrangements with one or more hospitals; a utilization review plan in effect; and operational policies developed with the advice of and reviewed by a professional group including at least one physician; and
- Is not an institution which is mainly a rest home; a home for the aged; a place for drug addicts; a place for alcoholics; or a place for the treatment of mental illness.

A skilled nursing facility that is part of a hospital, as defined in this document, will be considered a skilled nursing facility for the purposes of this Plan.

Special Food Product: [NRS 689B.0353] A food product that is specially formulated to have less than one gram of protein per serving and is intended to be consumed under the direction of a physician for the dietary treatment of an inherited metabolic disease. The term does not include a food that is naturally low in protein.

Specialist Physician: A doctor who has completed advanced education and training in a specific field of medicine.

Specialty Care Unit: A section, ward, or wing within a hospital that offers specialized care for the patient's needs. Such a unit usually provides constant observation, special supplies, equipment, and care provided by Registered nurses or other highly trained personnel. Examples include Intensive Care Units (ICU) and Cardiac Care Units (CCU).

Speech Therapy: Rehabilitation directed at treating defects and disorders of spoken and written communication.

Spinal Manipulation / Chiropractic Care: The detection and correction, by manual or mechanical means, of the interference with nerve transmissions and expressions resulting from distortion, misalignment, or dislocation of the spinal (vertebrae) column. Spinal manipulation is commonly performed by chiropractors, but it can be performed by physicians.

Spouse: The employee's lawful spouse**.** The Plan will require proof of the legal marital relationship. A legally separated spouse or divorced former spouse or domestic partner of an employee or retiree is not an eligible spouse under this Plan.

Standard Plan Benefits (Standard Benefits): Standard Plan Benefits or Standard Benefits under this Plan means the participant is covered under the Plan's Standard Benefits and is not eligible for enhanced benefits due to non-participating and or engaging in other programs such as the Obesity Care and Overweight Management Programs.

State: When capitalized in this document, the term State means the State of Nevada.

Step Therapy: A process designed to help control high medicine costs. If the Plan applies step therapy to your medication, it will require that you try a lower-cost medication that is proven effective to treat your condition, before it will cover a higher-cost medicine. If the lower cost medicine does not treat your condition effectively, the Plan's coverage will "step" you to a higher-cost medicine to find a medicine that treats your condition effectively at the lowest possible cost.

The Plan also complies with NRS 689B.0305 and NRS 695C.17333:

Sub-acute Care Facility: A public or private facility, either free-standing, hospital-based or based in a skilled nursing facility, licensed and operated according to law and authorized to provide sub-acute care, that primarily provides, immediately after or instead of acute care, comprehensive inpatient care for an individual who has had an acute illness, injury, or exacerbation of a disease process, with the goal of discharging the patient after a limited term of confinement, to the patient's home or to a suitable skilled nursing facility, and that meets all of the following requirements:

1. It is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) as a Sub-Acute Care Facility or is recognized by Medicare as a Sub-Acute Care Facility; and
2. It maintains on its premises all facilities necessary for medical care and treatment; and
3. It provides services under the supervision of physicians; and
4. It provides nursing services by or under the supervision of a licensed Registered Nurse; and
5. It is not (other than incidentally) a place for rest, domiciliary care, or care of people who are aged, alcoholic, blind, deaf, drug addicts, mentally deficient, or suffering from tuberculosis; and
6. It is not a hotel or motel.

Substance Abuse: A psychological and/or physiological dependence or addiction to alcohol or drugs or medications, regardless of any underlying physical or organic cause, and/or other drug dependency as defined by the current edition of the ICD manual or identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM). See the definitions of behavioral health disorders and chemical dependency.

Surgery/Surgeries: Any operative or diagnostic procedure performed in the treatment of an injury or illness by instrument or cutting procedure through an incision or any natural body opening. When more than one surgical procedure is performed through the same incision or operative field or at the same operative session, the claims administrator will determine which multiple surgical procedures will be considered as primary, secondary, bilateral, add-on, or separate (incidental) procedures for determining benefits under this Plan.

Multiple Surgical Procedure Allowances:

- Primary procedure, bilateral primary procedure, or add-on to primary procedure: usual and customary, subject to the Plan's Maximum Allowable Charge or negotiated fee.
- Secondary procedure in same operative area: limited to 50% of usual and customary charge, subject to the Plan's Maximum Allowable Charge or negotiated fee.
- Bilateral secondary procedure in same operative area: limited to 50% of usual and customary charge, subject to the Plan's Maximum Allowable Charge or negotiated fee.
- Add-on to secondary procedure in same operative area: limited to 100% of usual and customary charge, subject to the Plan's Maximum Allowable Charge or negotiated fee.
- Separate (incidental) procedure in same operative area as any of the above: not covered.
- Separate operative area: limited to 50% of usual and customary charge, subject to the Plan's Maximum Allowable Charge or negotiated fee.

Telehealth: Telehealth means the delivery of services from a provider of health care to a patient at a different location using information and audio-visual communication technology, not including facsimile, or electronic mail. See also NRS 629.515.

Telehealth is a general term used to describe clinical services provided to patients through electronic communications not through a vendor. This can be patient-to-physician. Examples include patient consultation with a specialist that is out of the patient's geographical area or patient has a virtual visit with their primary care physician. Telehealth is the use of digital information and communication technologies, such as computers and mobile devices, to access health care services remotely and manage your health.

Telemedicine: Telemedicine (vendor/virtual visit) is the practice of medicine using technology to deliver care at a distance via electronic communications through a vendor.

Temporomandibular Joint (TMJ), Temporomandibular Joint (TMJ) Dysfunction or Syndrome: The Temporomandibular (or craniomandibular) Joint (TMJ) connects the bone of the temple or skull (temporal bone) with the lower jawbone (the mandible). TMJ Dysfunction or Syndrome refers to a variety of symptoms where the cause is not clearly established, including (but not limited to) masticatory muscle disorders producing severe aching pain in and about the TMJ

(sometimes made worse by chewing or talking); myofascial pain, headaches, earaches, limitation of the joint, clicking sounds during chewing; tinnitus (ringing, roaring, or hissing in one or both ears) and/or hearing impairment. These symptoms may be associated with conditions such as malocclusion (failure of the biting surfaces of the teeth to meet properly), ill-fitting dentures, or internal derangement of the TMJ.

Therapist: A person trained in and skilled in giving therapy in a specific field of health care such as occupational, physical, radiation, respiratory and speech therapy. *See the Occupational, Physical and Speech Therapy* section.

Termination: Under the No Surprises Act, **i**ncludes, with respect to the Continuation of Care benefit, the expiration or nonrenewal of the contract, but does not include a termination of the contract for failure to meet applicable quality standards or for fraud.

Tortfeasor: Means an individual or entity who commits a wrongful act, either intentionally or through negligence, that injures another or for which the law provides a legal right through a civil case for the injured person to seek relief.

Transplant, Transplantation: The transfer of organs (such as the heart, kidney, liver) or living tissue/cells (such as bone marrow, stem cells or skin) from a donor to a recipient with the intent to maintain the functional integrity of the transplanted organ or tissue in the recipient. (See the *Schedule of Medical Benefits* and *Exclusions* section for additional information regarding transplants. See also the *Utilization Management* section of this document for information about precertification requirements for transplantation services).

Xerographic: Refers to transplants of organs, tissues, or cells from one species to another (for example, the transplant of an organ from a baboon to a human). Xerographic transplants are not covered by this Plan, except heart valves.

Urgent Care: Health care services that are required by the onset of a medical condition that manifests itself by symptoms of sufficient severity that prompt medical attention is appropriate, even though health and life are not in jeopardy. Examples of medical conditions that may be appropriate for urgent care include (but are not limited to) fever, sprains, bone, or joint injuries, continuing diarrhea, or vomiting, or bladder infections.

Urgent Care Claim: Means a claim for benefits that is treated in an expedited manner because the application of the time periods for making determinations that are not urgent care claims could seriously jeopardize the participant's life, health, or the ability to regain maximum function by waiting for a routine appeal decision. An urgent care claim also means a claim for benefits that, in the opinion of a physician with knowledge of the participant's medical conditions, would subject the participant to severe pain that cannot be adequately managed without the care or the treatment that is the subject of the claim. If an original request for precertification of an urgent care service was denied, the participant could request an expedited appeal for the urgent care claim.

Urgent Care Facility: A public or private hospital-based or free-standing facility, that includes x-ray and laboratory equipment and a life support system, licensed or legally operating as an urgent care facility, primarily providing minor emergency and episodic medical care with one or more physicians, nurses, and x-ray technicians in attendance when the facility is open.

Usual and Customary: Covered expenses which are identified by PEBP, taking into consideration the fee(s) which the provider most frequently charges (or accepts for) most patients for the service or supply, the cost to the provider for providing the services, the prevailing range of fees charged in the same "area" by providers of similar training and experience for the service or supply, and the Medicare reimbursement rates. The term(s) "same geographic locale" and/or "area" shall be defined as a metropolitan area, country, or such greater area as is necessary to obtain a representative cross- section of providers, persons or organizations rendering such treatment, services, or supplies for which a specific charge is made.

To be Usual and Customary, fee(s) must follow generally accepted billing practices for unbundling or multiple procedures.

The term "Usual" refers to the amount of a charge made or accepted for medical services, care, or supplies, to the extent that the charge does not exceed the common level of charges made by other medical professionals with similar credentials, or health care facilities, pharmacies, or equipment suppliers of similar standing, which are in the same geographic locale in which the charge is incurred.

The term "Customary" refers to the form and substance of a service, supply, or treatment provided in accordance with generally accepted standards of medical practice to one individual, which is appropriate for the care or treatment of the same sex, comparable age and who receive such services or supplies within the same geographic locale.

The term "Usual and Customary" does not necessarily mean the actual charge made nor the specific service or supply furnished to a participant by a provider of services or supplies, such as a physician, therapist, nurse, hospital, or pharmacist. The Plan Administrator will determine what the Usual and Customary charge is, subject to the Plan's Maximum Allowable Charge or negotiated fee schedule for any procedure, service, or supply, and whether a specific procedure, service or supply is usual and customary. Usual and customary charges may, at the Plan Administrator's discretion, alternatively be determined and established by the Plan using normative data such as, but not limited to, Medicare cost to charge ratios, Average Wholesale Price (AWP) for prescriptions and/or manufacturer's retail pricing (MRP) for supplies and devices.

Utilization Management (UM): A managed care process to determine the medical necessity, appropriateness, location, and cost-effectiveness of health care services. This review can occur before, during or after the services are rendered and may include (but is not limited to): precertification; concurrent and/or continued stay review; discharge planning; retrospective review; case management; hospital or other health care provider bill audits; and health care provider fee negotiation. Utilization management services (sometimes referred to as UM services, UM, utilization review services, UR services, utilization management, concurrent

review, or retro review services) are provided by licensed health care professionals employed by the utilization management company operating under a contract with the Plan.

Utilization Management Company (UM company): The independent utilization management organization, staffed with licensed health care professionals, who utilize nationally recognized health care screening criteria along with the medical judgment of their licensed health care professional, operating under a contract with the Plan to administer the Plan's utilization management services.

Visit: See the definition of office visit.

Well Baby Care; Well Child Care: Health care services provided to a healthy newborn or child that are determined by the Plan to be medically necessary, even though they are not provided because of illness, injury, or congenital defect. The Plan's coverage of well-baby care is described under *Preventive Care/Wellness Services* and in the *Schedule of Medical Benefits*.

You, Your: When used in this document, these words refer to the employee or retiree who is covered by the Plan. They do not refer to any dependent of the employee or retiree.

NEVADA PUBLIC EMPLOYEES' BENEFITS PROGRAM

Access.
Quality.
Affordability.

PEBP PPO DENTAL PLAN AND SUMMARY OF BENEFITS FOR LIFE INSURANCE

MASTER PLAN DOCUMENT

PLAN YEAR 2024

(EFFECTIVE JULY 1, 2023 – June 30, 2024)

Public Employees' Benefits Program
901 S. Stewart Street, Suite 1001
Carson City, Nevada 89701

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Amendment Log

Any amendments, changes or updates to this document will be listed here. The amendment log will include what sections are amended and where the changes can be found.

Welcome PEBP Participant

Welcome to the State of Nevada Public Employees' Benefits Program (PEBP). PEBP provides a variety of benefits such as medical, dental, life insurance, flexible spending accounts, and other voluntary insurance benefits for eligible state and local government employees, retirees, and their eligible dependents.

As a PEBP participant, you may enroll in whichever benefit plan offered in your geographical area that best meets your needs, subject to specific eligibility and Plan requirements. These plans include the Consumer Driven Health Plan (CDHP) with a Health Savings Account (HSA) or a Health Reimbursement Arrangement (HRA), (EPO) Plan, Low Deductible PPO Plan, and Health Plan of Nevada HMO Plan. (In general, Medicare retirees are required to enroll in a medical plan through PEBP's Medicare Exchange vendor). You are also encouraged to research plan provider access and quality of care in your service area.

This document describes PEBP's PPO Dental Plan, and Life Insurance Benefits. Active employees enrolled in a PEBP-sponsored medical plan (CDHP, EPO Plan. Low Deductible PPO Plan, or Health Plan of Nevada HMO Plan) receive dental and basic life. Retirees enrolled in a PEBP-sponsored medical plan receive dental coverage and if eligible, basic life insurance coverage. Eligible retirees enrolled in a medical plan through PEBP's Medicare Exchange receive basic life insurance and the choice to enroll in PEBP's voluntary PPO Dental Plan option.

PEBP participants should examine this document to become familiar with the PPO Dental Plan and basic life insurance benefits. In addition to examining this document, participants are encouraged to read the Master Plan Documents or Evidence of Coverage Certificates (EOCs), Summary Plan Descriptions, and Summary of Benefits and Coverage applicable to their medical plan. Participants should also examine the PEBP Enrollment and Eligibility, PEBP Active Employee Health and Welfare Wrap Plan Document, PEBP Retiree Health and Welfare Wrap Plan Document, Section 125, Medicare Exchange HRA Summary Plan Description, and other plan materials relevant to their benefits. These documents and other materials are available at www.pebp.state.nv.us or to request a particular document by mail, contact PEBP at 775-684-7000, (702) 486-3100, or 800-326-5496 or email member services by selecting the contact us feature in your E-PEBP portal member account.

In addition, helpful material is available from PEBP or any PEBP vendor listed in the *Participant Contact Guide*.

PEBP encourages you to stay informed of the most up to date information regarding your health care benefits. It is your responsibility to know and follow the plan provisions and other requirements described in PEBP's Master Plan Document and related materials.

Sincerely,

Public Employees' Benefits Program

Introduction

This Master Plan Document describes the PEBP self-funded PPO Dental Plan benefits offered to eligible employees, retirees, and their covered dependents. Additional benefits for life insurance are summarized in this document.

This PEBP plan is governed by the State of Nevada.

This document is intended to comply with the Nevada Revised Statutes (NRS) Chapter 287, and the Nevada Administrative Code 287 as amended and certain provisions of NRS 695G and NRS 689B.

The Plan described in this document is effective July 1, 2023, and unless stated differently, replaces all other self-funded Dental Benefit Plan documents and summary plan descriptions previously provided to you.

This document will help you understand and use the benefits provided by the Public Employees' Benefits Program (PEBP). You should review it and show it to members of your family who are or will be covered by the Plan. It will give you an understanding of the coverage provided, the procedures to follow in submitting claims, and your responsibilities to provide necessary information to the Plan. Be sure to read the *Exclusions*, and *Key Terms and Definitions* Sections. Remember, not every expense you incur for health care is covered by the Plan.

All provisions of this document contain important information. If you have any questions about your coverage or your obligations under the terms of the Plan, please contact PEBP at the number listed in the *Participant Contact Guide*. The *Participant Contact Guide* provides you with contact information for the various components of the Public Employees' Benefits Program.

PEBP intends to maintain this Plan indefinitely, but reserves the right to terminate, suspend, discontinue, or amend the Plan at any time and for any reason. As the Plan is amended from time to time, you will be sent information explaining the changes. If those later notices describe a benefit or procedure that is different from what is described here, you should rely on the later information. Be sure to keep this document, along with notices of any Plan changes, in a safe and convenient place where you and your family can find and refer to them.

The benefits offered with the Consumer Driven Health Plan, EPO Plan, Low Deductible PPO Plan, and Health Plan of Nevada include prescription drug benefits, dental coverage, and basic life insurance as applicable. The medical and prescription drug benefits are described in separately in the applicable plan's Master Plan Document or Evidence of Coverage certificate. An independent third-party claims administrator pays the claims for the PPO Dental Plan.

Per NRS 287.0485 no officer, employee, or retiree of the State has any inherent right to benefits provided under the PEBP.

Suggestions for Using this Document

This document provides important information about your benefits. We encourage you to pay attention to the following:

- The Table of Contents provides you with an outline of the sections.
- The *Participant Contact Guide* to become familiar with PEBP vendors and the services they provide.
- The *Participant Rights* section located in the Introduction of this document.
- The *Key Terms and Definitions* section explains many technical, medical, and legal terms that appear in the text.
- The *Eligible Dental Expenses*, *Schedule of Dental Benefits* and *Exclusions* sections describe your benefits in more detail.
- How to *File a Dental Claim* section to find out what you must do to file a claim.
- The *Appeals Procedures* section to find out how to request a review (appeal) if you are dissatisfied with a claims decision.
- The section on *Coordination of Benefits* discusses situations where you have coverage under more than one health care plan including Medicare. This section also provides you with information regarding how the plan subrogates with a third party who wrongfully caused an injury or illness to you.

Accessing Other Benefit Information:

Refer to the following plan documents for information related to dental, life, flexible spending accounts, enrollment and eligibility, COBRA, third-party liability and subrogation, HIPAA Privacy and Security and mandatory notices. These documents are available at *www.pebp.state.nv.us*.

- State of Nevada PEBP Active Employee Health and Welfare Wrap Plan; Retiree Health and Welfare Wrap Plan
- Consumer Driven Health Plan (CDHP) Master Plan Document (MPD); CDHP Summary of Benefits and Coverage for Individual and Family
- Low Deductible PPO Plan (LD PPO Plan) MPD; LD PPO Plan Summary of Benefits and Coverage (SBC) for Individual and Family
- PEBP PPO Dental Plan and Summary of Benefits for Basic Life Insurance MPD
- EPO Plan Master Plan Document; SBC for Individual and Family
- Health Plan of Nevada Evidence of Coverage of Benefits; Summary of Benefits and Coverage for Individual and Family
- PEBP Enrollment and Eligibility MPD
- Flexible Spending Accounts (FSA) Summary Plan Description
- Section 125 Health and Welfare Benefits Plan Document
- Medicare Retiree Health Reimbursement Arrangement Summary Plan Description

Participant Rights

You have the right to:

- Participate with your health care professionals and providers in making decisions about your health care.
- Receive the benefits for which you have coverage.
- Be treated with respect and dignity.
- Privacy of your personal health information, consistent with State and Federal laws, and the Plan's policies.
- Receive information about the Plan's organization and services, the Plan's network of health care professionals and providers and your rights and responsibilities.
- Candidly discuss with your physicians and providers appropriate or medically necessary care for your condition, regardless of cost or benefit coverage.
- Make recommendations regarding the organization's participants' rights and policies.
- Express respectfully and professionally, any concerns you may have about PEBP or any benefit or coverage decisions the Plan (or the Plan Administrator or its designee) makes.
- Refuse treatment for any conditions, illness, or disease without jeopardizing future treatment and be informed by your physician(s) of the medical consequences.

The plan is committed to:

- Recognizing and respecting you as a participant.
- Encouraging open discussion between you and your health care professionals and providers.
- Providing information to help you become an informed health care consumer.
- Providing access to health benefits and the plan's network (participating) providers.
- Sharing the plan's expectations of you as a participant.

Summary of PPO Dental Benefits

Eligible Dental Expenses

You are covered for expenses you incur for most, but not all, dental services and supplies provided by a dental care provider as defined in the *Key Terms and Definitions* section of this document that are determined by PEBP or its designee to be "medically necessary," but only to the extent that:

- The charges for them are "usual and customary (U&C)" (see Usual and Customary in the *Key Terms and Definitions* section).

Non-Eligible Dental Expenses

The plan will not reimburse you for any expenses that are not eligible dental expenses or medically unnecessary. That means you must pay the full cost for all expenses that are not covered by the Plan, as well as any charges for eligible dental expenses that exceeds this Plan's Usual and Customary determination.

Out-of-Country Dental Purchases

The PPO Dental Plan provides you with coverage worldwide. Whether you reside in the United States and you travel to a foreign country, or you reside outside of the United States, permanently or on a part-time basis and require dental care services, you may be eligible for reimbursement of the cost.

Typically, foreign countries do not accept payment directly from PEBP. You may be required to pay for dental care services and submit your receipts to PEBP's third party administrator for reimbursement. Dental services received outside of the United States are subject to Plan provisions, limitations and exclusions, clinical review if necessary and determination of medical necessity. The review may include regulations determined by the FDA.

Prior to submitting receipts from a foreign country to PEBP's third party administrator, you must complete the following. (PEBP and this Plan's third-party administrator reserve the right to request additional information if needed):

- Proof of payment from you to the provider of service (typically your credit card invoice).
- Itemized bill to include complete description of the services rendered.
- Itemized bill must be translated to English.
- Any costs associated with the reimbursement request must be converted to United States dollars; and

Any foreign purchases of dental care and services will be subject to Plan limitations such as:

- Benefits and coverage under the Plan
- Deductibles
- Coinsurance
- Frequency maximums
- Annual benefit maximums

- Medical necessity
- FDA approval
- Usual and Customary (U & C)

Once payment is made to you or to the out of country provider, PEBP and its vendors are released from any further liability for the out of country claim. PEBP has the exclusive authority to determine the eligibility of all dental services rendered by an out of country provider. PEBP may or may not authorize payment to you or to the out of country provider if all requirements of this provision are not satisfied.

Note: Please contact this Plan's third-party administrator before traveling or moving to another country to discuss any criteria that may apply to a dental service reimbursement request.

Deductibles

Each Plan Year, you must satisfy the Plan Year Deductible before the Plan will pay benefits for Basic or Major dental services. Eligible dental expenses for preventive services are not subject to the Plan Year Deductible or the annual maximum benefit. Benefits for some services are available four times each Plan Year, for example preventive cleanings and periodontal maintenance cleanings. Oral examinations and bitewing x-rays are available twice per Plan Year. If a person covered under this Plan changes status from an employee or retiree to a dependent, or from a dependent to an employee and the person is continuously covered under this Plan before, during and after the change in status, credit will be given for portions of the Deductible already met, and accumulation of benefit maximums will continue without interruption.

There are two types of Deductibles: Individual and Family. The Individual Deductible is the maximum amount one covered person must pay each Plan Year before plan benefits are available for Basic or Major dental services. **The Plan's Individual Deductible is $100**. The Family Deductible is the maximum amount a family of three or more is required to pay in a Plan year. **The plan's family Deductible is $300**. The Family Deductible is accumulative meaning that one member of the family cannot satisfy the entire Family Deductible. Both in- and out-of-network services are combined to meet your Plan Year Deductible.

Coinsurance

There is no Coinsurance amount for preventive services unless services are rendered by a non-PPO dental provider. For Basic or Major dental services, once you have met your Plan Year Deductible, the Plan pays its percentage of the eligible Usual and Customary dental expenses, and you are responsible for paying the rest (the applicable percentage paid by the Plan is shown in the Schedule of Dental Benefits). The part you pay is called the Coinsurance. Note: Your out-of-pocket expenses will be less if you use the services of a dental care provider who is part of the Preferred Provider Organization (PPO), also called in-network.

Plan Year Maximum Dental Benefits

The Plan Year maximum dental benefits payable for any individual covered under this Plan is **$2,000**. The Plan Year maximum dental benefit is combined to include both in-network and out-of-network services. Under no circumstances will the combination of in-network and out-of-network benefit payments exceed the Plan Year maximum benefit. This maximum does not

include your Deductible or any amounts over Usual and Customary. Benefits paid for eligible preventive dental services do not apply to the annual maximum dental benefit.

There is no plan year maximum for dependent children under age 19.

Payment of Dental Benefits

When charges for dental services and supplies are incurred, services and supplies are considered to have been incurred on the date the services are performed or on the date the supplies are furnished. However, this rule does not apply to the following services because they must be performed over a period of time.

- Fixed partial dentures, bridgework, crowns, inlays and onlays: All services related to installation of fixed partial dentures, bridgework, crowns, inlays and onlays are considered to have been incurred on the date the tooth (or teeth) is (or are) prepared for the installation.
- Removable partial or complete dentures: All services related to the preparation of removable partial or complete dentures are considered to have been incurred on the date the impression for the dentures is taken.
- Root canal treatment (endodontics): All services related to root canal treatment are considered incurred on the date the tooth is opened for the treatment.

Extension of Dental Coverage

If dental coverage ends for any reason, the Plan will pay benefits for you or your covered dependents through the last day of the month in which the coverage ends. The Plan will also pay benefits for a limited time beyond that date for the following:

- A prosthesis (such as a full or partial denture) if the dentist took the impressions and prepared the abutment teeth while you or your dependents were covered and installs the device within 31 days after coverage ends.
- A crown, if the dentist prepared the crown while you or your dependent(s) were covered and installs it within 31 days after coverage ends.
- Root canal treatment, if the dentist opened the tooth while you or your dependent(s) were covered and completes the treatment within 31 days after coverage ends.

Dental Pretreatment Estimates

Whenever you expect that your dental expenses for a course of treatment will be more than $300, you are encouraged to obtain a pretreatment estimate from the third-party claims administrator. This procedure lets you know how much you will have to pay before you begin treatment.

To obtain a pretreatment estimate, you and your dentist should complete the regular dental claim form (available from and to be sent to the third-party claims administrator, whose name and address are listed on the *Participant Contact Guide* in this document), indicating the type of work to be performed also referred to as a treatment plan, along with supporting x-rays and the estimated cost (valid for a 60-day period following the submission of the pretreatment estimate request). Once it is received, the third-party claims administrator will review the treatment plan and then send your dentist a statement within the next 60 days showing what the Plan may pay. Your dentist

may call the third-party claims administrator for a prompt determination of the benefits payable for a dental procedure.

Prescription Drugs Needed for Dental Purposes

Necessary prescription drugs needed for a dental purpose, such as antibiotics or pain medications, should be obtained using the prescription drug benefit provided under your medical plan.

NOTE: Some medications for a dental purpose are not payable, such as fluoride or periodontal mouthwash. See the *Medical Exclusions* section under Drugs for more information.

Voluntary PPO Dental Plan Option for Medicare Retirees Enrolled through VIA Benefits

Medicare retirees enrolled in a medical plan through VIA Benefits (Medicare Exchange) and those retirees with Tricare for Life and Medicare Parts A and B who are eligible for a Medicare Exchange Health Reimbursement Arrangement (HRA) have the option to enroll in PEBP's PPO Dental Plan. Enrollment in PEBP's PPO Dental Plan requires automatic dental premium reimbursement from the retiree's Health Reimbursement Arrangement (HRA). The dental premium will only be reimbursed up to the amount in retiree's HRA. When the amount of the dental premium is more than the unused amount in the retiree's HRA, the amount of the premium will be carried forward in the retiree's HRA until the unused amount in the HRA is sufficient to reimburse for the dental premium.

Dental Network

In-Network Services

In-network dental care providers have agreements with the Plan under which they provide dental care services and supplies for a favorable negotiated discount fee for Plan participants. When a Plan participant uses the services of an in-network dental care provider, except with respect to any applicable deductible, the Plan participant is responsible for paying only the applicable Coinsurance for any medically necessary services or supplies. The in-network dental care provider generally deals with the Plan directly for any additional amount due.

The Plan's Preferred Provider Organization (PPO) is contracted with PEBP to provide a network of dental care providers located within a service area (defined below) and who have agreed to provide dental care services and supplies for favorable negotiated discount fees applicable only to Plan participants. Because providers are added and dropped from the PPO network periodically throughout the year, it is the participant's responsibility to verify provider participation each time before seeking services by contacting the PPO network. The PPO dental network's telephone number and website are listed on the *Participant Contact Guide* in this document.

If you receive medically necessary dental services or supplies from a PPO dental care provider, you will pay less money out of your own pocket than if you received those same services or supplies from a dental provider who is not a PPO provider because these providers discount their fees. Using PPO dental care providers means that you can obtain more dental services before reaching your Plan Year dental benefit maximum. In addition to receiving discounted fees for dental services, the PPO provider has agreed to accept the Plan's allowed payment, plus any applicable Coinsurance that you are responsible for paying, as payment in full.

The directory of dental care providers is available at www.pebp.state.nv.us. To request a hard copy of the directory, please call the PPO Dental Network shown in the *Participant Contact Guide* in this document.

Out-of-Network Services

Out-of-network (non-network) dental care providers have no agreements with the Plan and are generally free to set their own charges for the services or supplies they provide. For participants receiving services outside of Nevada, the Plan will reimburse the Plan participant for the usual and customary charge for any medically necessary services or supplies, subject to the Plan's Deductibles, Coinsurance, copayments, limitations, and exclusions.

If a participant travels to an area serviced by the Plan's PPO network, the participant should use an in-network provider to receive benefits at the in-network benefit level. If a participant uses an out-of-network provider within this service area, benefits will be considered as out-of-network. In-network provider contracted rates for the Diversified Dental Las Vegas service area will apply to all out-of-network dental claims in Nevada. The participant may be responsible for any amount billed by the out-of-network provider that exceeds the in-network provider contracted rate. Plan

participants may be required to submit proof of claim before any such reimbursement will be made. Non-network dental care providers may bill the Plan participant for any balance that may be due in addition to the amount payable by the Plan, also called balance billing. You can avoid balance billing by using in-network providers.

When Out-of-Network Providers May be Paid as In-Network Providers?

If a participant lives more than 50 miles from an in-network PPO provider, resides, or travels outside of Nevada, benefits for an out-of-network provider will be considered at the in-network benefit level. Usual and customary allowance will apply. The participant may be responsible for any amount billed by the provider that exceeds the usual and customary allowance.

A “service area” is a geographic area serviced by the in-network dental care providers who have agreements with the Plan’s PPO dental network. If you and/or your covered dependent(s) live more than 50 miles from the nearest in-network dental care provider, the Plan will consider that you live outside the service area. In that case, your claim for services by an out-of-network dental care provider will be treated as if the services were provided in-network.

Schedule of Dental Benefits

Schedule of Dental Benefits (All benefits are subject to the Deductible except where noted) See also the *Exclusions*, and *Key Terms and Definitions* sections of this document for important information)		
Benefit Description	**In-Network**	**Out-of-Network**
Preventive Services • Oral examination • Prophylaxis (routine cleaning of the teeth without the presence of periodontal disease) • Bitewing X-Rays • Topical application of sodium or stannous fluoride • Space maintainers • Application of sealants	No Deductible 100% of the discounted allowed fee schedule	No Deductible 80% of the in-network provider fee schedule for the Las Vegas service area For services outside of Nevada, the Plan will reimburse at the U&C rates

Explanations and Limitations

- Preventive services are not subject to the individual Plan Year maximum dental benefit.
- Oral examinations are limited to four times per Plan Year.
- Prophylaxis, scaling, cleaning, and polishing limited to four times per Plan Year. Even if your dentist recommends more than four routine prophylaxes, the Plan will only consider four for benefit purposes. You will be responsible for charges in excess of four cleanings in a single Plan Year.
- Bitewing x-rays limited to twice per Plan Year.
- Fluoride treatment for individuals aged 18 years and under is payable twice per Plan Year.
- Application of sealants for children under age 18 years.
- Initial installation of a space maintainer (to replace a primary tooth until a permanent tooth comes in) is payable for individuals under age 16 years. Plan allows fixed, unilateral (band or stainless-steel crown type), fixed cast type (distal shoe), or removable bilateral type.
- Benefits for preventive dental services do not apply to the annual maximum dental benefit.
- Out-of-Network: The Plan pays 80% of the in-network provider fee schedule for the Las Vegas service area. For services outside of Nevada, the Plan will reimburse at the U&C rates.

Schedule of Dental Benefits

(All benefits are subject to the Deductible except where noted)
See also the *Exclusions*, and *Key Terms and Definitions* Sections of this document for important information)

Benefit Description	In-Network	Out-of-Network
Basic Services	After the Deductible is met, the Plan pays 80% of the discounted allowed fee schedule	After the Deductible is met, Plan pays 50% of the in-network provider fee schedule for the Las Vegas service area. For services outside of Nevada, the Plan will reimburse at the U&C rates

Explanations and Limitations

- Plan Year Deductible applies
- Dental visit during regular office hours for treatment and observation of injuries to teeth and supporting structures (other than for routine operative procedures)
- After hours for emergency dental care
- Consultation by a specialist for case presentation when a general dentist has performed diagnostic procedures
- Emergency treatment
- Film fees, including examination and diagnosis, except for injuries
- Dental CT scans are allowed at varying frequencies depending on the type of service.
- Periapical, entire dental film series (14 films), including bitewings as necessary every 36 months **or** panoramic survey covered once every 36 months
- Basic services are subject to the individual Plan Year maximum dental benefit.
- Full-mouth periodontal maintenance cleanings, payable four times per Plan Year. Even if your dentist recommends more than four periodontal maintenance cleanings, the Plan will only consider four for benefit purposes. You will be responsible for charges in excess of four cleanings in a single Plan Year
- Laboratory services, including cultures necessary for diagnosis and/or treatment of a specific dental condition
- For multiple restorations, one tooth surface will be considered a single restoration
- Out-of-Network: After deductible, the Plan pays 80% of the in-network provider fee schedule for the Las Vegas service area. For services outside of Nevada, the Plan will reimburse at the U&C rates.
- Biopsy, examination of oral tissue, study models, microscopic exam.
- Emergency palliative treatment for pain.
- Uncomplicated oral surgery is surgery not identified as “complex oral surgery.” Oral surgery is limited to removal of teeth, incision, and drainage.
- Complex oral surgery means procedures including surgical extractions of teeth, impactions, alveoloplasty or alveolectomy, vestibuloplasty, and residual root removal, including local anesthesia and postoperative care.

- Amalgam restorations for primary and permanent teeth, synthetic, silicate, plastic and composite fillings, retention pin when used as part of restoration other than a gold restoration
- Appliance for thumb sucking (individuals under 16 years of age)
- Occlusal guard or night guard.
- Dental CT scans, depending on the type and necessity are allowed by the Plan. Contact the claims administrator for more information. You must have the CDT code of your requested procedure before calling
- Initial installation of a removable, fixed or cemented inhibiting appliance to correct thumb sucking is payable for individuals under age 16 years
- No coverage for root canal therapy when the pulp chamber was opened before coverage under this dental plan began
- Out-of-Network: After deductible, the Plan pays 80% of the in-network provider fee schedule for the Las Vegas service area. For services outside of Nevada, the Plan will reimburse at the U&C rates.

Schedule of Dental Benefits

(All benefits are subject to the Deductible except where noted)
See also the *Exclusions*, and *Key Terms and Definitions* Sections of this document for important information)

Benefit Description	In-Network	Out-of-Network
Major Services	After the Deductible is met, Plan pays 50% of the discounted allowed fee schedule.	After the Deductible is met, Plan pays 50% of the in-network provider fee schedule for the Las Vegas service area For services outside of Nevada, the Plan will reimburse at the U&C rates

Explanations and Limitations

- Plan Year Deductible applies to Major services
- Major services are subject to the individual Plan Year maximum dental benefit
- No coverage for a crown, bridge, or gold restoration when the tooth was prepared before coverage under the dental Plan began
- Facings on crowns or pontics posterior to the second bicuspid are considered cosmetic and not covered. Gold restorations (inlays and onlays) covered only when teeth cannot be restored with a filling material
- Repair or re-cementing of inlays, crowns, bridges, and dentures which are 5 years old or more and cannot be repaired.

- Initial installation of fixed or removable bridges, dentures and full or partial dentures (except for special characterization of dentures) including abutment crowns
- Bridgework, dentures, and replacement of bridgework and dentures which are 5 years old or more and cannot be repaired. Covered expenses for temporary and permanent services cannot exceed the usual and customary fees for permanent services
- Dental implants (endosseous, ridge extension, and ridge augmentation only) which are 5 years old or more and cannot be repaired.
- Post and core on non-vital teeth only
- Denture relining and/or adjustment more than six months after installation
- Prosthodontics (artificial appliance of the mouth). No coverage of fees to install or modify an appliance for which an Impression was made before coverage under this dental plan began
- Crown (acrylic, porcelain, or gold with gold or non-precious metal), including crown build up only when teeth cannot be restored with a filling material
- Teeth added to a partial denture to replace extracted natural teeth, including clasps if needed
- If payment is requested for temporary appliances, the cost of the temporary appliance will be deducted from the benefits payable for the permanent appliance, meaning the Plan will not pay for both a temporary and a permanent appliance
- Under no circumstances will the benefit paid for a temporary appliance and permanent appliance exceed the PPO allowed amount or usual and customary allowance

Benefit Limitations and Exclusions: PPO Dental Plan

The following is a list of dental services and supplies or expenses not covered by the PPO Dental Plan. The Plan Administrator and its designees will have discretionary authority to determine the applicability of these exclusions and the other terms of the Plan and to determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan.

Analgesia, Sedation, Hypnosis, etc.: Expenses for analgesia, sedation, hypnosis, and/or related services provided for apprehension or anxiety.

Any treatment or service for which you have no financial liability or that would be provided at no cost in the absence of dental coverage.

Concierge membership fees: Expenses for fees described or defined as membership, retainer or premiums that are paid to a concierge dental practice to have access to the dental services provided by the concierge dental practice.

Cosmetic Services: Expenses for dental surgery or dental treatment for cosmetic purposes, as determined by the Plan Administrator or its designee, including but not limited to all veneers regardless of medical necessity, and facings. However, the following will be covered if they otherwise qualify as covered dental expenses and are not covered under your medical expense coverage:

- Reconstructive dental surgery when that service is incidental to or follows surgery resulting from trauma, infection, or other diseases of the involved part.
- Surgery or treatment to correct deformities caused by sickness.
- Surgery or treatment to correct birth defects outside the normal range of human variation.
- Reconstructive dental surgery because of congenital disease or anomaly of a covered dependent child resulting in a functional disorder.

Costs of Reports, Bills, etc.: Expenses for preparing dental reports, bills or claim forms; mailing, shipping, or handling expenses; and charges for broken appointments, telephone calls and/or photocopying fees.

Expenses Exceeding Maximum Plan Benefits: Expenses that exceed any Plan benefit limitation or Plan Year maximum benefits (as described in the *Dental Expense Coverage* section).

Drugs and Medicines: Expenses for prescription drugs and medications that are covered under your medical expense coverage, and for any other dental services or supplies if benefits as otherwise provided under the Plan's medical expense coverage; or under any other plan or program that the PEBP contributes to or otherwise sponsors (such as HMOs); or through a medical or dental department, clinic or similar facility provided or maintained by the PEBP.

Duplication of Dental Services: If a person covered by this Plan transfers from the care of one dentist to the care of another dentist during the course of any treatment, or if more than one dentist renders services for the same dental procedure, the Plan will not be liable for more than the amount that it would have been liable had but one dentist rendered all the services during each course of treatment, nor will the Plan be liable for duplication of services.

Duplicate or Replacement Bridges, Dentures or Appliances: Expenses for any duplicate or replacement of any lost, missing, or stolen bridge, denture, or orthodontic appliance, other than replacements described in the *Major Services* section of the *Schedule of Dental Benefits*.

Education Services and Home Use: Supplies and/or expenses for dental education such as for plaque control, oral hygiene or diet or home use supplies, including, but not limited to, toothpaste, toothbrush, water-pick type device, fluoride, mouthwash, dental floss, etc.

Expenses Exceeding Usual and Customary or the PPO Allowable Fee Schedule: Any portion of the expenses for covered dental services or supplies that are determined by the Plan Administrator or its designee to exceed the usual and customary charge or PPO fee schedule (as defined in the Definitions section of this document).

Expenses for Which a Third Party Is Responsible: Expenses for services or supplies for which a third party is required to pay because of the negligence or other tortuous or wrongful act of that third party (see the provisions relating to Third Party Liability in the section on *Coordination of Benefits*).

Expenses Incurred Before or After Coverage: Expenses for services rendered or supplies provided before the patient became covered under the dental program, or after the date the patient's coverage ends (except under those conditions described in the Extension of Dental Benefits in the *Dental Expense Coverage* section or under the COBRA provisions of the Plan).

Experimental and/or Investigational Services: Expenses for any dental services, supplies, drugs or medicines that are determined by the claims administrator or its designee to be experimental and/or investigational (as defined in the *Key Terms and Definitions* section of this document).

Frequent Intervals Services: Services provided at more frequent intervals than covered by the PPO Dental Plan as described in the *Schedule of Dental Benefits*.

Gnathologic Recordings for Jaw Movement and Position: Expenses for gnathologic recordings (measurement of force exerted in the closing of the jaws) as performed for jaw movement and position.

Hospital Expenses Related to Dental Care Expenses: Expenses for hospitalization related to dental surgery or care, except as otherwise explained in this document. Contact the claims administrator for more information if you require this service.

Illegal Act: Expenses incurred by any covered individual for injuries resulting from commission, or attempted commission by the covered individual, of an illegal act that PEBP determines

involves violence or the threat of violence to another person or in which a firearm is used by the covered individual. PEBP's discretionary determination that this exclusion applies shall not be affected by any subsequent official action or determination with respect to prosecution of the covered individual (including, without limitation, acquittal, or failure to prosecute) in connection with the acts involved.

Installation or Replacement of Appliances: Restorations or procedures for altering vertical dimension.

Medically Unnecessary Services or Supplies: As determined by PEBP or its designee not to be medically necessary (as defined in the *Definitions* section of this document.) This includes procedures that are not indicated due to insufficient evidence of efficacy, including, but not limited to, Adjunctive Pre-Diagnostic Tests, Oral Cancer screenings, etc.

Mouth Guards: Expenses for athletic mouth guards and associated devices.

Myofunctional*:* Therapy expenses for myofunctional therapy.

Non-Dental Expenses: Services rendered or supplies provided that are not recommended or prescribed by a dentist.

Occupational Illness, Injury or Conditions Subject to Workers' Compensation: All expenses incurred by you or any of your covered dependents arising out of or in the course of employment (including self-employment) if the injury, illness, or condition is subject to coverage, in whole or in part, under any workers' compensation or occupational disease or similar law.

This applies even if you or your covered dependent were not covered by workers' compensation insurance, or if the covered individual's rights under workers' compensation or occupational disease or similar law have been waived or qualified.

Orthodontia: Expenses for any dental services relating to orthodontia evaluation and treatment.

Periodontal Splinting: Expenses for periodontal splinting (tying two or more teeth together when there is bone loss to gain additional stability).

Personalized Bridges, Dentures, Retainers or Appliances: Expenses for personalization or characterization of any dental prosthesis, including but not limited to any bridge, denture, retainer, or appliance.

Reconstructive Dental Surgery: When that service is:

- Incidental to or follows surgery resulting from trauma, infection, or other diseases of the involved part.
- Surgery or treatment to correct deformities caused by sickness.
- Surgery or treatment to correct birth defects outside the normal range of human variation.

- Reconstructive dental surgery because of congenital disease or anomaly of a covered dependent child resulting in a functional disorder.

Services Not Performed by a Dentist or Dental Hygienist: Expenses for dental services not performed by a dentist (except for services of a dental hygienist that are supervised and billed by a dentist and are for cleaning or scaling of teeth or for fluoride treatments).

Treatment of Jaw or Temporomandibular Joints (TMJ): Expenses for treatment, by any means, of jaw joint problems including temporomandibular joint (TMJ) dysfunction disorder and appliances.

Treatment of Disturbances of the temporomandibular joint, craniomandibular dysfunctions, myofacial pain syndrome, or any other disorder of the joint linking the jaw to the skull and the associated muscles. This exclusion does not pertain to temporomandibular joint radiographs.

War or Similar Event: Expenses incurred as a result of an injury or illness due to you or your covered dependents participation in any act of war, either declared or undeclared, war-like act, riot, insurrection, rebellion, or invasion, except as required by law.

Self-Funded PPO Dental Claims Administration

How Dental Benefits are Paid

Plan benefits are considered for payment on the receipt of written proof of claim, commonly called a bill. Generally, health care providers send their bill to PEBP's third-party administrator directly. Plan benefits for eligible services performed by health care providers will then be paid directly to the provider delivering the services. When Deductibles, Coinsurance or copayments apply, you are responsible for paying your share of these charges.

If services are provided through the PPO dental network, the PPO dental provider may submit the proof of claim directly to PEBP's third-party administrator; however, you will be responsible for the payment to the PPO dental care provider for any applicable Deductible, Coinsurance, or copayments.

If a dental care provider does not submit a claim directly to PEBP's third-party administrator and instead sends the bill to you, you should follow the steps outlined in this section regarding *How to File a Claim*. If, at the time you submit your claim, you furnish evidence acceptable to the Plan Administrator or its designee (PEBP's third-party administrator) that you or your covered dependent paid some or all of those charges, Plan benefits may be paid to you, but only up to the amount allowed by the Plan for those services after Plan Year Deductible, Coinsurance and copayment amounts are met.

How to File a Dental Claim

All claims must be submitted to the Plan within 12 months from the date of service. No Plan benefits will be paid for any claim submitted after this period. Benefits are based on the Plan's provisions in place on the date of service.

Most providers send their bills directly to the PEBP's third-party administrator; however, for providers who do not bill the Plan directly, you may be sent a bill. In that case, follow these steps:

- Obtain a claim form from PEBP's third-party administrator or in your E-PEBP portal member account (see the *Participant Contact Guide* in this document for details on address, phone and website).
- Complete the participant part of the claim form in full. Answer every question, even if the answer is "none" or "not applicable (N/A)."
- The instructions on the claim form will tell you what documents or medical information is necessary to support the claim. your physician, health care practitioner or dentist can complete the health care provider part of the claim form, or you can attach the itemized bill for professional services if it contains all the following information:
- A description of the services or supplies provided including appropriate procedure codes.
- Details of the charges for those services or supplies.
- Appropriate diagnosis code.

- Date(s) the services or supplies were provided.
- Patient's name.
- Provider's name, address, phone number, and professional degree or license.
- Provider's federal tax identification number (TIN).
- Provider's signature.

Please review your bills to be sure they are appropriate and correct. Report any discrepancies in billing to the third-party administrator. This can reduce costs to you and the Plan. Complete a separate claim form for each person for whom Plan benefits are being requested. If another plan is the primary payer, send a copy of the other plan's explanation of benefits (EOB) along with the claim you submit to this Plan.

To assure that medical, pharmacy or dental expenses you incur are eligible under this Plan, the Plan has the right to request additional information from any hospital, facility, physician, laboratory, radiologist, dentist, pharmacy or any other eligible medical or dental provider. For example, the Plan has the right to deny deductible credit or payment to a provider if the provider's bill does not include or is missing one or more of the following components. This is not an all-inclusive list.

- Itemized bill to include but not be limited to: Proper billing codes such as CPT, HCPCS, Revenue Codes, CDT, and ICD 10.
- Date(s) of service.
- Place of service.
- Provider's Tax Identification Number.
- Provider's signature.
- Operative report.
- Patient ledger.
- Emergency room notes.

NOTE: Claims are processed by PEBP's third-party administrator in the order they are received.

NOTE: It is your responsibility to maintain copies of the explanation of benefits provided to you by PEBP's third party administrator or prescription drug administrator. Explanation of benefits documents are available on the third-party administrator's website application but cannot be reproduced.

Where to Send the Claim Form

Send the completed claim form, the bill you received (you keep a copy, too) and any other required information to the third-party administrator at the address listed in the *Participant Contact Guide* in this document.

Dental Appeal Process

Written Notice of Denial of Claim

The Plan's third-party administrator will notify you in writing on an Explanation of Benefits (EOB) of an Adverse Claim Determination (see *Adverse Determination* in the *Key Terms and Definitions* section) resulting in a denial, reduction, termination, or failure to provide or make payments (in whole or in part) of a benefit. The notice will explain the reasons why, with reference to the Plan provisions as to the basis for the adverse determination and it will explain what steps to take to submit a Level 1 Claim Appeal.

You will be provided with:

(a) upon request and without charge, reasonable access to and copies of all relevant documents, records and other information relevant to your claim for benefits;

(b) the opportunity to submit written comments, documents, records and other information relating to the claim for benefits;

(c) a full and fair review that takes into account all comments, documents, records and other information submitted by you, without regard to whether such information was submitted or considered in the initial benefit determination;

(d) automatically and free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the denied claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date.

Additionally, before the Plan issues an Adverse Benefit Determination on review based on a new or additional rationale, you will be provided, automatically and free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you reasonable time to respond prior to that date.

If the Plan receives new or additional evidence or rationale so late in the claim filing or claim appeal process that a claimant would not have a reasonable opportunity to respond, the period for providing a final determination is delayed until such time as the claimant has had such an opportunity.

When applicable, the notice will explain what additional information is required from you and why it is needed. A participant or their designee cannot circumvent the claims and appeals procedures by initiating a cause of action against the PEBP (or the State of Nevada) in a court proceeding.

The appeal process works as follows:

Level 1 Appeal

NAC 287.670

If your claim is denied, or if you disagree with the amount paid on a claim, you may request a Level 1 Claim Appeal from the third-party administrator within 180 days of the date you received the Explanation of Benefits (EOB) which provides the claim determination. Failure to request a Level 1 Claim Appeal in a timely manner will be deemed to be a waiver of any further right of review of appeal under the Plan, unless good cause can be demonstrated. The written request for appeal must include:

- The name and Social Security Number, or identification number of the participant.
- A copy of the EOB related to the claim being appealed; and
- A detailed written explanation why the claim is being appealed.

You have the right to review documents applicable to the denial and to submit your own comments in writing. The third-party administrator will review your claim (by a person at a higher level of management than the one who originally denied the claim). If any additional information is needed to process your request for appeal, it will be requested promptly.

The third-party administrator will issue a decision of your Level 1 Claim Appeal in writing within 20 days after receipt of your request for appeal.

You will receive a notice of the appeal determination. If that determination is adverse, it will include at each level of the appeal review, the following:

(a) information that is sufficient to identify the claim involved (e.g. date of service, health care provider, claim amount if applicable);
(b) the statement that, upon request and free of charge, the diagnosis code and/or treatment code, and their corresponding meanings, will be provided. However, a request for this information will not be treated as a request for a 2nd level of appeal or external review (when external review is applicable);
(c) the specific reason(s) for the adverse appeal review decision, including the denial code and its corresponding meaning and a discussion of the decision, as well as any Plan standards used in denying the claim;
(d) reference the specific Plan provision(s) on which the determination is based;
(e) a statement that you are entitled to receive upon request, free access to and copies of documents relevant to your claim;
(f) an explanation of the Plan's appeal process and Level 2 appeal process and the external review process (when external review is applicable), along with any time limits and information regarding how to initiate the next level of review, as well as a statement of the voluntary Plan appeal procedures, if any;
(g) if the denial was based on an internal rule, guideline, protocol or similar criterion, a statement will be provided that such rule, guideline, protocol or criteria that was relied upon will be provided free of charge to you, upon request;
(h) if the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request;

(i) the statement that "You and your Plan may have other voluntary dispute resolution options such as mediation. One way to find out what may be available is to contact your local U. S. Department of Labor Office and your State insurance regulatory agency;" and

disclosure of the availability of, and contact information for, any applicable health insurance consumer assistance or ombudsman established under the Public Health Services Act to assist individuals with internal claims and appeals and external review processes (when external review is applicable).

The notification will explain the steps necessary if you wish to proceed to a Level 2 Appeal if you are not satisfied with the response at Level 1.

Level 2 Appeal

NAC 287.680

If you are unsatisfied with the Level 1 Claim Appeal decision made by the third-party administrator, you may file a Level 2 Claim Appeal to the PEBP Executive Officer or designee by completing a Claim Appeal Request form. *Claim Appeal Request form*s are available at *www.pebp.state.nv.us* or by request by contacting PEBP Customer Service at 775-684-7000 or 800-326-5496. A Level 2 Appeal must be submitted to PEBP within 35 days after you receive the Level 1 Appeal determination. Your Level 2 Appeal must include a copy of:

- Any document submitted with your Level 1 Appeal request.
- A copy of the Level 1 Appeal decision; and
- Any documentation to support your request.

The Executive Officer or designee will use all resources available to assure a thorough review is completed in accordance with provisions of the Plan.

A Level 2 Appeal decision will be given to you in writing by certified mail within 30 days after the Level 2 Appeal request is received by the Executive Officer or designee. A Level 2 Appeal determination will explain and reference the reasons for the decision, including the applicable provisions of the Plan upon which the determination is based.

Standard Request for External Claim Review

NAC 287.690

An External Claim Review may be requested by a participant and/or the participant's treating physician after exhausting the Level 1 and Level 2 Claim Appeals process. This means that you may have a right to have the Plan's or its designee's decision reviewed by independent health care professionals if the adverse benefit determination involved making a judgment as to the medical necessity, appropriateness, health care setting, level of care or effectiveness of the health care setting or treatment you requested.

An External Claim Review request must be submitted in writing to the Office for Consumer Health Assistance (OCHA) within four (4) months after the date of receipt of a notice of the Level 2 Claim

Appeal decision. An *External Review Request Form* is available on the PEBP website at *www.pebp.state.nv.us*. *The* OCHA will assign an independent external review organization within five (5) days after receiving the request. The external review organization will issue a determination within 15 days after it receives the complete information. For standard Request for External Claim Review, a decision will be made within 45 days of receiving the request.

A Request for External Claim Review must include:

- completed and signed External Review Request Form.
- a copy of the EOB(s) related to the claim(s) being reviewed.
- a detailed written explanation why the external review is being requested; and
- any additional supporting documentation.

The Request for External Claim Review must be submitted to:

Office for Consumer Health Assistance
555 East Washington #4800
Las Vegas, NV 89101
Phone: (702) 486-3587,
(888) 333-1597
Fax 702-486-3586
Web: *http://dhhs.nv.gov/Programs/CHA/Contact_GovCHA/*

Coordination of Benefits (COB)

For information, refer to the separate PEBP Health and Welfare Wrap Document available at www.pebp.state.nv.us under “4.4 Coordination of Benefits” (NAC 287.755).

Third Party Liability and Subrogation

Subrogation and Rights of Recovery

Subrogation applies to situations where the Participant is injured, and another person or entity is or may be responsible, liable, or contractually obligated, for whatever reason, for the payment of certain damages or claims arising from or related in any way to the Participant's injury (the "Injury"). These damages or claims arising from the Injury, irrespective of the way they are categorized, may include, without limitation, medical expenses, pain and suffering, loss of consortium, and/or wrongful death. The Plan has a right of subrogation irrespective of whether the damages or claims are paid or payable to the Participant, the Participant's estate, the Participant's survivors, or the Participant's attorney(s). Any and all payments made by the Plan for which it claims a right of subrogation are referred to as Subrogated Payments.

The subrogation provision provides the Plan with a right of recovery for certain payments made by the Plan, irrespective of fault, or negligence wrongdoing. Any and all payments made by the Plan relating in any way to the injury may be recovered directly from the other person or from any judgment, verdict or settlement obtained by the participant in relation to the injury.

The Participant must cooperate fully, at all times, and provide all information needed or requested by the Plan to recover payments, execute any papers necessary for such recovery, and do whatever is necessary or requested in order to secure and protect the Subrogation rights of the Plan. The Participant's required cooperation includes, but is not limited to, the following actions, which must be performed immediately, upon request by the Plan:

1) Executing an acknowledgment form or other document acknowledging and agreeing to protect the Plan's right of Subrogation.
2) Cooperating and participating in the Plan's recovery efforts, including but not limited to participating in litigation commenced or pursued by the Plan or its Board; and
3) Filing a claim or demand with another insurance company, including but not limited to the Participant's own first party insurance policy or another person's or entity's insurance policy.

Refer to the separate PEBP Active Employee Health and Welfare Benefits Wrap Plan Document and PEBP Retiree Health and Welfare Benefits Wrap Plan Document available at *www.pebp.state.nv.us* for more information regarding third party liability and subrogation.

The Participant must cooperate fully, at all times, and provide all information needed or requested by the Plan to recover payments, execute any papers necessary for such recovery, and do whatever is necessary or requested in order to secure and protect the Subrogation rights of the Plan. The Participant's required cooperation includes, but is not limited to, the following actions, which must be performed immediately, upon request by the Plan:

1) Executing an acknowledgment form or other document acknowledging and agreeing to protect the Plan's right of Subrogation.
2) Cooperating and participating in the Plan's recovery efforts, including but not limited to participating in litigation commenced or pursued by the Plan or its Board; and
3) Filing a claim or demand with another insurance company, including but not limited to the Participant's own first party insurance policy or another person's or entity's insurance policy.

Refer to the separate PEBP Active Employee Health and Welfare Benefits Wrap Plan Document and PEBP Retiree Health and Welfare Benefits Wrap Plan Document available at *www.pebp.state.nv.us* for more information regarding third party liability and subrogation.

Basic Life Insurance

This section provides a summary of the fully insured group basic life insurance available from PEBP. Since this is only a summary, for complete information you must refer to the Certificate of Coverage Booklet available from the insurance company who insures this benefit. Their name and contact information are listed in the *Participant Contact Guide* section of this document.

Eligibility for Life Insurance

To be eligible for the basic life insurance, you must be enrolled under the PEBP sponsored medical Plan, and be in one of the following classes:

- Class 1: Full-time employees of the State of Nevada (or any non-State agency approved by the PEBP board), professional full-time employees of the Nevada System of Higher Education (under annual contract), and members of the Nevada Senate or Assembly are all eligible for this benefit. A full-time employee is one who works at least 80 hours per month. Your employer pays the full cost of Basic Life Insurance.

- Class 2: retirees of the State of Nevada receiving PERS, or judge retirement benefits and legislators qualifying under Chapter 242 of the Sessions Law of the sixty-third Session of the Nevada State Legislature (or NRS 287.045), professional employees qualifying per NAC 287.135, and retirees eligible to join PEBP upon retirement pursuant to NRS 287.023 are eligible for this benefit. Reinstated retirees are not eligible for basic life insurance benefits or voluntary life Insurance coverage. Certain retirees pay a contribution toward the cost of basic life insurance.

Coverage

Basic Life Insurance Benefits are as follows:

Basic Life Insurance	Class 1 (employee) Benefit Amount	Class 2 (retiree) Benefit Amount
Life insurance amount	$15,000	$7,500

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Public Employees' Benefits Program (PEBP) 901 S. Stewart Street, Suite 1001 Carson City, NV 89701 Customer Service: (775) 684-7000, (702) 486-3100, or (800) 326-5496 Fax: (775) 684-7028 *www.pebp.state.nv.us*	**Plan Administrator** • Enrollment and eligibility • COBRA information and premium payments • Level 2 claim appeals • External review coordination
UMR Claims Submission P O Box 30541 Salt Lake City, UT 84130-0541 EDI #39026 Appeal of Claims P O Box 30546 Salt Lake City, UT 84130-0546 Customer Service: (888) 763-8232 www.UMR.com Diabetes Care Management form submission UMR 27 Corporate Hill Drive Little Rock, AR 77205 Fax: 800-458-0701 Email: diabetes@HealthscopeBenefits.com	**Third-party Claims Administrator/Third-party Administrator/PPO Network/Disease Management Administrator for Diabetes** • Claim submission • Claim status inquiries • Level 1 claim appeals • Verification of eligibility • Plan Benefit Information • CDHP & Dental only ID Cards • Obesity Care Management Program • Disease Care Management Program • Sierra Health-Care Options (SHO) – Southern Nevada PPO Network • UnitedHealthcare Choice Plus – Outside of Southern Nevada PPO Network • Behavioral Health-Care Options (BHO) – Behavioral Health Network in Nevada
Sierra Health-Care Options, Inc Utilization Management Company PO BOX 15645 Las Vegas, NV 89144-5648 Customer Service : 888-323-1461 Fax : 800-288-2264	• Pre Certification/Prior Authorization • Utilization Management • Case Management • Transplants

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Express Scripts Pharmacy Benefit Administrator Customer Service and Prior Authorization (855) 889-7708 www.Express-Scripts.com Accredo Patient Customer Service (800) 803-2523 Accredo Physician Service Line (800) 987-4904 option 5 Express Scripts / Accredo Prior Authorization (800) 753-2851 Electronic options: express-scripts.com/PA Specialty Medication SaveOnSP copay assistance (800) 683-1074 www.saveonsp.com/pebp~~**Express Scripts Pharmacy Benefit Administrator**~~ ~~Customer Service and Prior Authorization~~ ~~(855) 889-7708~~ ~~*www.Express-Scripts.com*~~ ~~**Express Scripts Home Delivery**~~ ~~PO Box 66566~~ ~~St. Louis, MO 63166-6566~~ ~~Customer Service: (855) 889-7708~~ ~~**Accredo Specialty Pharmacy**~~ ~~Customer Service: (855) 889-7708~~ ~~**Express Scripts Benefit Coverage Review Department**~~ ~~PO Box 66587, St. Louis, MO 63166-6587~~ ~~Phone: 800-946-3979~~ ~~**Express Scripts Clinical Appeals Department**~~ ~~PO Box 66588 St. Louis, MO 63166-6588~~ ~~Phone: 800-753-2851~~ ~~Fax: 877-852-4070~~ ~~**MCMC LLC**~~ ~~**Attn: Express Scripts Appeal Program**~~ ~~300 Crown Colony Dr. Suite 203~~ ~~Quincy, MA 02169-0929~~	Pharmacy Benefit Manager for the CDHP, LD PPO Plan, and EPO Plan Prescription drug information • Retail network pharmacies • Prior authorization • Price a Medication tool • Home Delivery service and Mail Order forms • Preferred Mail Order for diabetic supplies • Accredo Specialty Drug Services • Coverage and Clinical reviews, appeals

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~~617-375-7700 ext. 28253 / Fax: 617-375-7683~~	
Diversified Dental Services 5470 Kietzke Lane, Ste 300 Reno, NV 89511 ProviderRelations@ddsppo.com 1-866-270-8326 diversifieddental.com	PPO Dental Network • Statewide PPO Dental Providers • Dental Provider directory • National PPO Dental Providers outside of Nevada utilizes the Principal Dental Network
Health Plan of Nevada (702) 242-7300 or (877) 545-7378 *www.stateofnv.healthplanofnevada.com*	Southern Nevada Health Maintenance Organization (HMO) • Medical claims/provider network
VIA Benefits 10975 Sterling View Drive, Suite A1 South Jordan, UT 84095 (888)598-7545 *https://my.viabenefits.com/pebp* Phone: (888) 598-7545; Fax: (402) 231-4310	Medicare Exchange • Medigap (Supplemental) plans • Medicare Advantage Plans (HMO and PPO) • Voluntary Vision • Voluntary Dental • HRA claims administrator
United Healthcare Group Number: 370074 Customer Service: 1-888-763-8232 UnitedHealthcare Specialty Benefits P.O. Box 7149 Portland, ME 04112-7149	• Basic Life Insurance for eligible active and retirees
Office for Consumer Health Assistance 555 E. Washington Avenue, Suite 4800 Las Vegas, NV 89101 Customer Service: (702) 486-3587 or (888) 333-1597 *http://dhhs.nv.gov/Programs/CHA/Contact_Gov CHA/*	**Consumer Health Assistance** • Concerns and problems related to coverage • Provider billing issues • External review information
The Living Will Lockbox c/o Nevada Secretary of State 101 North Carson St., Ste. 3 Carson City, NV 89701 Phone: (775) 684-5708; Fax: (775) 684-7177	**Living Will Information** • Declaration governing life-sustaining treatment/do not resuscitate order • Durable power of attorney for health care decisions

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https://www.nvsos.gov/sos/online-services/nevada-lockbox	

Key Terms and Definitions

The following terms or phrases are used throughout the MPD. These terms or phrases have the following meanings. These definitions do not, and should not be interpreted to, extend coverage under the Plan.

Accident: A sudden and unforeseen event that is not work-related, resulting from an external or extrinsic source.

Adverse Benefit Determination: A determination that an admission, availability of care, continued stay or other health care service that is a covered benefit has been reviewed, and, based upon the information provided, does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, and the requested service or payment for the service is therefore denied, reduced, or terminated.

Allowable Expense: A health care service or expense, including Deductibles or Coinsurance, that is covered in full or in part by any of the plans covering a plan participant (see also the *COB section* of this document), except as otherwise provided by the terms of this Plan or where a statute applicable to this Plan requires a different definition. This means that an expense or service (or any portion of an expense or service) that is not covered by any of the plans is not an allowable expense.

Ancillary Services: Services provided by a hospital or other health care facility other than room and board, including (but not limited to) use of the operating room, recovery room, intensive care unit, etc., and laboratory and x-ray services, drugs and medicines, and medical supplies provided during confinement.

Anesthesia: The condition produced by the administration of specific agents (anesthetics) to render the patient unconscious and without conscious pain response (e.g., general anesthesia), or to achieve the loss of conscious pain response and/or sensation in a specific location or area of the body (e.g., regional or local anesthesia). Anesthetics are commonly administered by injection or inhalation.

Annual: For the purposes of this Plan, annual refers to the 12-month period starting July 1 through June 30.

Appliance (dental): A device to provide or restore function or provide a therapeutic (healing) effect.

Appropriate: See the definition of medically necessary for the definition of appropriate as it applies to medical services that are medically necessary.

Average Wholesale Price (AWP): the average price at which drugs are purchased at the wholesale level.

Base Plan: The Self-Funded Consumer Driven Health Plan (CDHP). The base Plan is also defined as the "default Plan" where applicable in this document and other communication materials produced by PEBP (NRS 287.045).

Benefit, Benefit Payment, Plan Benefit: The amount of money payable for a claim, based on the usual and customary charge, after calculation of all Deductibles, Coinsurance, and copayments, and after determination of the Plan's exclusions, limitations, and maximums.

Bitewing X-Rays (dental): Dental x-rays showing the coronal (crown) halves of the upper and lower teeth when the mouth is closed.

Bridge, Bridgework (dental) Fixed: A prosthesis that replaces one or more teeth and is cemented in place to existing abutment teeth. It consists of one or more pontics and one or more retainers (crowns or inlays). The patient cannot remove the prosthesis.

Business Day: Refers to all weekdays, except Saturday or Sunday, or a Nevada Holiday or federal holiday.

Claims Administrator: The person or company retained by the Plan to administer claim payment responsibilities and other administration or accounting services as specified by the Plan.

Coinsurance: That portion of eligible medical expenses for which the covered person has financial responsibility. In most instances, the covered individual is responsible for paying a percentage of covered medical expenses in excess of the Plan's Deductible. The Coinsurance varies depending on whether in-network or out-of-network providers are used.

Coordination of Benefits (COB): The rules and procedures applicable to the determination of how plan benefits are payable when a person is covered by two or more health care plans. (See also the *Coordination of Benefits* section).

Cosmetic Surgery or Treatment: Surgery or medical treatment to improve or preserve physical appearance, but not physical function. Cosmetic surgery or treatment includes (but is not limited to) removal of tattoos, breast augmentation, or other medical, dental, or surgical treatment intended to restore or improve physical appearance, as determined by the Plan Administrator or its designee.

Course of Treatment (Dental): The planned program of one or more services or supplies, provided by one or more dentists, to treat a dental condition diagnosed by the attending dentist as a result of an oral examination. The course of treatment begins when a dentist first renders a service to correct or treat the diagnosed dental condition.

Covered Dental Expenses: See the definition of *Eligible Dental Expenses*.

Crown (Dental): The portion of a tooth covered by enamel. An artificial crown is a dental prosthesis used to return a tooth to proper occlusion, contact and contour, as used as a restoration or an abutment for a fixed prosthesis.

Customary Charge: See the definition of Usual and Customary Charge.

Deductible: The amount of eligible dental expenses you are responsible for paying before the Plan begins to pay benefits. The amount of deductibles is discussed in the *Dental Expense Coverage* section of this document.

Dependent Child(ren): See also (NAC 287.312). For the purposes of this Plan, a dependent child is any of your children under the age of 26 years, including:

- natural child,
- child(ren) of a domestic partner,
- stepchild,
- legally adopted child or child placed in anticipation for adoption (the term placed for adoption means the assumption and retention by the employee of a legal obligation for total or partial support of the child in anticipation of adoption of the child and the child must be available for adoption and the legal adoption process must have commenced),
- child who qualifies for benefits under a QMCSO/NMSN (see the *Eligibility* section for details on QMCSO/NMSN),
- any other person who:

(1) Bears a relationship described in 26 U.S.C. § 152(c)(2) to the participant or his or her spouse or domestic partner.

(2) Is unmarried.

Dental: As used in this document, dental refers to any services performed by (or under the supervision of) a dentist, or supplies (including dental prosthetics). Dental services include treatment to alter, correct, fix, improve, remove, replace, reposition, restore or treat: teeth; the gums and tissues around the teeth; the parts of the upper or lower jaws that contain the teeth (the alveolar processes and ridges); the jaw, any jaw implant, or the joint of the jaw (the temporomandibular joint); bite alignment, or the meeting of upper or lower teeth, or the chewing muscles; and/or teeth, gums, jaw or chewing muscles because of pain, decay, malformation, disease or infection. Dental services and supplies are covered under the dental expense coverage plan and are not covered under the medical expense coverage of the Plan unless the medical plan specifically indicates otherwise in the Schedule of Medical Benefits.

For injury to teeth see *Injury to Sound and Natural Teeth*, below.

Dental Care Provider: A dentist, dental hygienist nurse, or other health care practitioner (as those terms are specifically defined in this section of the document) who is legally licensed and who is a dentist or performs services under the direction of a licensed dentist; and acts within

the scope of his or her license; and is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

Dental Subspecialty Areas:

Subspecialty Area	Services related to the diagnosis, treatment, or prevention of diseases
Endodontics	The dental pulp and its surrounding tissues.
Implantology	Attachment of permanent artificial replacement of teeth directly to the jaw using artificial root structures.
Oral Surgery	Extractions and surgical procedures of the mouth.
Orthodontics	Abnormally positioned or aligned teeth.
Pedodontics	Treatment of dental problems of children.
Periodontics	Structures that support the teeth (gingivae, alveolar bone, periodontal membrane or ligament, cementum).
Prosthodontics	Construction of artificial appliances for the mouth (bridges, dentures, crowns, implants).

Dental Hygienist: A person who is trained, legally licensed, and authorized to perform dental hygiene services (such as prophylaxis, or cleaning of teeth), under the direction of a licensed dentist; and who acts within the scope of his or her license; and is neither the patient, the parent, spouse, sibling (by birth or marriage) nor child of the patient.

Dental Implant: A dental implant is an artificial tooth root that is placed into your jaw to hold a replacement tooth or bridge.

Dentist: A person holding the degree of Doctor of Dental Surgery (DDS) or Doctor of Dental Medicine (DMD) who is legally licensed and authorized to practice all branches of dentistry under the laws of the state or jurisdiction where the services are rendered; and acts within the scope of his or her license.

Denture: A device replacing missing teeth.

Domestic Partner: As defined by NRS 122A.030.

Eligible Dental Expenses: Expenses for dental services or supplies, but only to the extent that they are medically necessary, as defined in this *Key Terms and Definitions* section; and the

charges for them are usual and customary, as defined in this *Key Terms and Definitions* section; and coverage for the services or supplies is not excluded, as provided in the *Dental Exclusions* section of this document and the Plan Year maximum dental benefits for those services or supplies has not been reached.

Employee: Unless specifically indicated otherwise when used in this document, employee refers to a person employed by an agency or entity that participates in the PEBP program, and who is eligible to enroll for coverage under this Plan.

Exclusions: Specific conditions, circumstances, and limitations, as set forth in the *Exclusions* section for which the Plan does not provide Plan benefits.

Explanation of Benefits (EOB): When a claim is processed by the claims administrator you will be sent a form called an explanation of benefits, or EOB. The EOB describes how the claim was processed, such as allowed amounts, amounts applied to your deductible, if your Out-of-Pocket Maximum has been reached, if certain services were denied and why, amounts you need to pay to the provider, etc.

FAIR Health: FAIR Health is an independent nonprofit that collects data for and manages the nation's largest database of privately billed health insurance claims and is entrusted with Medicare Parts A, B and D claims data for 2013 to the present. This data is widely used in the industry to determine market appropriate benchmark pricing for medical and dental services. (https://www.fairhealth.org/about-us)

Fixed Appliance: A device that is cemented to the teeth or attached by adhesive materials.
Fluoride: A solution applied to the surface of teeth, or a prescription drug (usually in pill form) to prevent dental decay.

Food and Drug Administration (FDA): The U.S. government agency responsible for administration of the Food, Drug and Cosmetic Act and whose approval is required for certain prescription drugs and other medical services and supplies to be lawfully marketed.

Government-Provided Services (Tricare/CHAMPUS, VA, etc.): Expenses for services when benefits are provided to the covered individual under any plan or program in which any government participates (other than as an employer), unless the governmental program provides otherwise.

Health Care Practitioner: A physician, behavioral health practitioner, chiropractor, dentist, nurse, nurse practitioner, physician assistant, podiatrist, or occupational, physical, respiratory or speech therapist or speech pathologist, master's prepared audiologist, optometrist, optician for vision plan benefits, oriental medicine doctor for acupuncture or Christian Science Practitioner, who is legally licensed and/or legally authorized to practice or provide certain health care services under the laws of the state or jurisdiction where the services are rendered: and acts within the scope of his or her license and/or scope of practice.

Health Care Provider: A health care practitioner as defined above, or a hospital, ambulatory surgical facility, behavioral health treatment facility, birthing center, home health care agency, hospice, skilled nursing facility, or sub-acute care facility (as those terms are defined in this *Definitions* section).

HIPAA: Health Insurance Portability and Accountability Act of 1996. Federal Regulation affecting portability of coverage; electronic transmission of claims and other health information; privacy and confidentiality protections of health information.

HIPAA Special Enrollment: Enrollment rights under HIPAA for certain employees and dependents who experience a loss of other coverage and when there is an adoption, placement for adoption, birth, or marriage.

Impression: A negative reproduction of the teeth and gums from which models of the jaws are made. These models are used to study certain conditions and to make dental appliances and prostheses.

Injury to Teeth: An injury to the teeth caused by trauma from an external source.

Benefits for injury to teeth are payable under the medical plan.

Inlay: A restoration made to fit a prepared tooth cavity and then cemented into place (see the definition of restoration).

In-Network Services: Services provided by a health care provider that is a member of the Plan's Preferred Provider Organization (PPO), as distinguished from out-of-network services that are provided by a health care provider that is not a member of the PPO network.

In-Network Contracted Rate: The negotiated amount determined by the PPO network to be the maximum amount charged by the PPO provider for a covered service. In some cases, the in-network contracted amount may be applied to out-of-network provider charges.

Medically Necessary: A medical or dental service or supply will be determined to be "medically necessary" by the Plan Administrator or its designee if it:

- is provided by or under the direction of a physician or other duly licensed health care practitioner who is authorized to provide or prescribe it (or dentist if a dental service or supply is involved); and
- is determined by the Plan Administrator or its designee to be necessary in terms of generally accepted American medical and dental standards; and
- is determined by the Plan Administrator or its designee to meet all the following requirements:
  - It is consistent with the symptoms or diagnosis and treatment of the illness or injury; and
  - It is not provided solely for the convenience of the patient, physician, dentist, hospital, health care provider, or health care facility; and

- It is an "appropriate" service or supply given the patient's circumstances and condition; and
- It is a level of service that can be safely provided to the patient; and
- It is safe and effective for the illness or injury for which it is used.

A hospitalization or confinement to a health care facility will not be considered to be medically necessary if the patient's illness or injury could safely and appropriately be diagnosed or treated while not confined.

A medical or dental service or supply that can safely and appropriately be furnished in a physician's or dentist's office or other less costly facility will not be considered to be medically necessary if it is furnished in a hospital or health care facility or other more costly facility.

- The non-availability of a bed in another health care facility, or the non-availability of a health care practitioner to provide medical services will not result in a determination that continued confinement in a hospital or other health care facility is medically necessary.
- A medical or dental service or supply will not be considered to be medically necessary if it does not require the technical skills of a dental or health care practitioner or if it is furnished mainly for the personal comfort or convenience of the patient, the patient's family, any person who cares for the patient, any dental or health care practitioner, hospital or health care facility.

Non-Network: See Out-of-Network Services.

Non-Participating Provider: A health care provider who does not participate in the Plan's Preferred Provider Organization (PPO).

Office Visit: A direct personal contact between a dentist or other dental care practitioner and a patient in the dental care practitioner's office for diagnosis or treatment associated with the use of the appropriate office visit code in the Current Dental Terminology (CDT) manual of the American Dental Association and with documentation that meets the requirement of such CDT coding.

Onlay: An inlay restoration that is extended to cover the biting surface of the tooth, but not the entire tooth. It is often used to restore lost and weakened tooth structure.

Oral Surgery: The specialty of dentistry concerned with surgical procedures in and about the mouth and jaw.

Orthodontics, Orthodontia: The science of the movement of teeth to correct a malocclusion or "crooked teeth."

Orthognathic Services: Services dealing with the cause and treatment of malposition of the bones of the jaw, such as prognathism, retrognathism or TMJ syndrome. See the definitions of Prognathism, Retrognathism and TMJ.

Out-of-Network, Out-of-Network Services (Non-Network): Services provided by a health care provider that is not a member of the Plan's Preferred Provider Organization (PPO), as distinguished from in-network services that are provided by a health care provider that is a member of the PPO. Greater expense could be incurred by the participant when using out-of-network providers.

Outpatient Services: Services provided either outside of a hospital or health care facility setting or at a hospital or health care facility when room and board charges are not incurred.

Partial Denture: A Prosthesis that replaces one or more, but less than all, of the natural teeth and associated structures. The denture may be removable or fixed.

Participating Provider: A health care provider who participates in the Plan's Preferred Provider Organization (PPO).

Periodontal Disease: Bacterial gum infections that destroy gum tissue and supporting bone that hold teeth in place.

Pharmacy: A licensed establishment where covered prescription drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he or she practices.

Pharmacist: A person legally licensed under the laws of the state or jurisdiction where the services are rendered, to prepare, compound and dispense drugs and medicines, and who acts within the scope of his or her license.

Plan, The Plan, This Plan: In most cases, the programs, benefits, and provisions described in this document as provided by the Public Employees' Benefits Program (PEBP).

Plan Administrator: The person or legal entity designated by the Plan as the party who has the fiduciary responsibility for the overall administration of the Plan.

Plan Year: Typically, the 12-month period from July 1 through June 30. PEBP has the authority to revise the Plan Year if necessary. PEBP has the authority to revise the benefits and rates if necessary, each Plan Year. For medical, dental, vision and pharmacy benefits, all deductibles, Out-of-Pocket Maximums and Plan Year maximum benefits are determined based on the Plan Year.

Plan Year Deductible: The amount you must pay each Plan Year before the Plan pays benefits.

Plan Year Maximum Benefits: The maximum amount of benefits payable each Plan Year for certain dental expenses incurred by any covered plan participant (or any covered family member of the plan participant) under this Plan.

Plan Participant; Participant: The employee or retiree or their enrolled spouse or domestic partner or dependent child(ren) or a surviving spouse of a retiree.

Pontic: The part of a fixed bridge that is suspended between two abutments and replaces a missing tooth.

Post-Service Claim: Means any claim for benefits under a health benefit plan regarding payment of benefits that is not considered a pre-service claim or an urgent care claim.

Preferred Provider Organization (PPO): A group or network of health care providers (*e.g.,* hospitals, physicians, laboratories) under contract with the Plan to provide health care services and supplies at agreed-upon discounted/reduced rates.

Pre-Service/Dental Pre-Estimate: Means any estimate for benefits under a health benefit plan with respect to which the terms of the Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining dental care.

Prescribed for a Medically Necessary Indication: The term medically accepted indication means any use of a covered outpatient drug which is approved under the Federal Food, Drug and Cosmetic Act, or the use of which is supported by one or more citations included or approved for inclusion in any of the following compendia: American Hospital Formulary Service Drug Information, United States Pharmacopeia-Drug Information, the DRUGDEX Information System or American Medical Association Drug Evaluations.

Prescription Drugs: For the purposes of this Plan, prescription drugs include:

1. **Federal Legend Drugs:** Any medicinal substance that the Federal Food, Drug and Cosmetic Act requires to be labeled, "Caution — Federal Law prohibits dispensing without prescription."
2. **Other Prescription Drugs:** Drugs that require a prescription under state law but not under federal law.
3. **Compound Drugs:** Any drug that has more than one ingredient and at least one of them is a Federal Legend Drug or a drug that requires a prescription under state law.

Prognathism: The malposition of the bones of the jaw resulting in projection of the lower jaw beyond the upper part of the face.

Program: The Public Employees' Benefits Program established in accordance with NRS 287.0402 to 287.049, inclusive.

Prophylaxis: The removal of tartar and stains from the teeth. The cleaning and scaling of the teeth are performed by a dentist or dental hygienist.

Prosthesis (dental): An artificial replacement of one or more natural teeth and/or associated structures.

Prosthetic Appliance (dental): A removable device that replaces a missing tooth or teeth.

Provider: See the definition of health care provider.

Removable: A prosthesis that replaces one or more teeth and which are held in place by clasps. The patient can remove the prosthesis.

Restoration: A broad term applied to any filling, crown, bridge, partial denture, or complete denture that restores or replaces loss of tooth structure, teeth, or oral tissue. The term applies to the result of repairing and restoring or reforming the shape and function of part or all the tooth or teeth.

Retiree: Unless specifically indicated otherwise, when used in this document, retiree refers to a person formerly employed by an agency or entity that may or may not participate in the PEBP program and who is eligible to enroll for coverage under this Plan.

Retrognathism: The malposition of the bones of the jaw resulting in the retrogression of the lower jaw from the upper part of the face.

Root Canal (Endodontic) Therapy: Treatment of a tooth having damaged pulp. The treatment is usually performed by completely removing the pulp, sterilizing the pulp chamber and root canals, and filling these spaces with a sealing material.

Root Planning and Scaling: Also known as conventional periodontal therapy, non-surgical periodontal therapy, or deep cleaning, is the process of removing or eliminating dental plaque and calculus, which cause inflammation.

Service Area: The geographic area serviced by the in-network health care or dental providers who have agreements with the Plan's PPO networks. Refer to the *Participant Contact Guide* for additional information regarding the PPO networks.

Sound and Natural Teeth: Natural teeth (not dentures, bridges, pontics or artificial teeth) that are free of active or chronic clinical decay; and have at least 50% bone support; and are functional in the arch; and have not been excessively weakened by previous dental procedures.

Spouse: The employee's lawful spouse (opposite sex or same sex) as determined by the laws of the State of Nevada**.** The Plan will require proof of the legal marital relationship. A former spouse or domestic partner of an employee or retiree is not an eligible spouse under this Plan.

State: When capitalized in this document, the term State means the State of Nevada.

Subrogation: This is a technical legal term for the right of one party to be substituted in place of another party in a lawsuit. See the *Third Party Liability* section of this document for an explanation of how the Plan may use the right of subrogation to be substituted in place of a covered individual in that person's claim against a third party who wrongfully caused that person's injury or illness, so that the Plan may recover medical benefits paid if the covered individual recovers any amount from the third party either by way of a settlement or judgment in a lawsuit.

Tier of Coverage: The category of rates and premiums or contributions for coverage that correspond to either an eligible participant only, or an eligible participant and one or more eligible dependents.

Temporomandibular Joint (TMJ), Temporomandibular Joint (TMJ) Dysfunction or Syndrome: The temporomandibular (or craniomandibular) joint (TMJ) connects the bone of the temple or skull (temporal bone) with the lower jawbone (the mandible). TMJ dysfunction or syndrome refers to a variety of symptoms where the cause is not clearly established, including (but not limited to) masticatory muscle disorders producing severe aching pain in and about the TMJ (sometimes made worse by chewing or talking); myofacial pain, headaches, earaches, limitation of the joint, clicking sounds during chewing; tinnitus (ringing, roaring or hissing in one or both ears) and/or hearing impairment. These symptoms may be associated with conditions such as malocclusion (failure of the biting surfaces of the teeth to meet properly), ill-fitting dentures, or internal derangement of the TMJ.

Topical: Painting the surface of teeth, as in a fluoride treatment or application of a cream-like anesthetic formula to the surface of the gum.

Tortfeasor: Means an individual or entity who commits a wrongful act, either intentionally or through negligence, that injures another or for which the law provides a legal right through a civil case for the injured person to seek relief.

Usual and Customary Charge (U&C): While your medical or dental care provider may charge whatever they feels services are worth, the Plan has the right to determine what it will allow as the usual and customary charge, sometimes referred to as usual and customary fee or allowable fee or prevailing fee. The usual and customary charge for medically necessary services or supplies will be determined by the claims administrator or Plan Administrator and will be the lowest of:

- With respect to a PPO (in-network) participating medical health care or dental care provider, the fee set forth in the agreement between the PPO network or the claims administrator or the Plan Administrator and the participating medical health care or dental care provider. or
- The medical health care or dental care provider's actual charge; or
- The usual charge by the medical health care or dental care provider for the same or similar service or supply.
- For out-of-network medical or dental services, no more than the 70th percentile of fair health. FAIR Health is a national schedule of prevailing health care charges that is updated twice per year. Information regarding FAIR Health is located on the PEBP website.
- For services provided by an out-of-network medical or dental care provider that are not addressed by FAIR Health, the claims administrator or the Plan Administrator may refer to the PPO (in-network) fee schedule of the nearest (geographically) or the most prevalently used PPO provider of the nearest

(geographically) for the same or similar service when determining the usual and customary charge by the out-of-network provider.

The "prevailing charge" of most other health care or dental care providers in the same or similar geographic area for the same or similar health care service or supply will be determined by the claims administrator using proprietary data that is provided by a reputable company or entity and is updated no less frequently than annually. The Plan will not always pay benefits equal to or based on the health care or dental care provider's actual charge for health care services or supplies, even after you have paid the applicable Deductible and Coinsurance. This is because the Plan covers only the usual and customary charge for health care services or supplies. Any amount in excess of the usual and customary charge does not count toward the Plan Year's Out-of-Pocket Maximum. The usual and customary charge is sometimes referred to as the U & C charge, the reasonable and customary charge, the R & C charge, the usual, customary, and reasonable charge, or the UCR charge. Note: to obtain the most current usual and customary amount, please contact PEBP's claims administrator, listed in the *Participant Contact Guide* in this document. You must provide the claims administrator with the specific procedure code, provider name and the zip code for the location where the procedure will take place. This service is only available to PEBP plan participants.

NOTE: The Claims Administrator has the discretionary authority to determine the usual and customary charge based upon standards set forth by the Plan Administrator.

Visit: See the definition of Office Visit.

You, your: When used in this document, these words refer to the employee or retiree who is covered by the Plan. They do not refer to any dependent of the employee or retiree.